University of Alberta

SEEKING COMMON GROUND: EXPERIENCES OF NURSES AND MIDWIVES

by

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ABSTRACT

Midwifery is a newly regulated healthcare profession in British Columbia and since being registered community-based midwives have been granted privileges at hospitals throughout the province. Although some midwifery clients choose homebirth, approximately two-thirds birth in the hospital setting. The choice of, or necessity for, these women to be hospitalized for childbirth has brought hospital-based perinatal nurses and community-based midwives into shared care situations for midwifery clients and their babies.

This inquiry explores nurses' and midwives' experience of interprofessional interaction in the context of this shared care. In-depth, one-on-one conversations with eleven midwives and ten perinatal nurses provided rich anecdotes and accounts of their practices with childbearing women, both separately and together. A hermeneutic phenomenological approach was taken to orient to this phenomenon of interprofessional relation, guide conversations with participants, describe their experiences and elucidate the meanings uncovered in them.

In their words, participants revealed both similar and different understandings of the meaning of birth that arise from the epistemic views in which their practices are based. Both nurses and midwives provide intense relational support for childbearing women. However, these relationships are shaped in different ways by the temporal and contextual factors that circumscribe the care they provide.

This study reveals that when interacting with one another nurses and midwives often experience confusion and frustration due to the assumptions, expectations and

misunderstandings that arise from mistrust of one another's approaches to childbirth and interpretation of risk. The experience of difference and otherness that overwhelms situations where collaboration is expected inhibits collegiality and occasionally results in conflict that can threaten or disrupt the moral space of birth for women and their babies. Through largely negative exemplars, the thread of ethical collegiality is traced to find the common ground in which reconciliation, collaboration, and the desire to embrace difference can be found. Drawing from the philosophical work of Irigaray, Levinas and Derrida themes of difference, relational responsibility, welcome, and hospitality are developed and brought into an understanding of birth as the sign of transformation, reconciliation, and the ground of our being-in-relation.

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For Peter,

who has given unstinting love and support

throughout the gestation, labour and birth of this project.

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CHAPTER ONE

ORIENTING TO THE PHENOMENON

When I began to conceive this study as an exploration of the interactions between nurses and midwives I discussed the idea informally with other nurses, midwives, and women who had experienced midwifery care. Although almost all were enthusiastic and many had personal experiences to illustrate the potential importance of this exploration, one midwife said to me, "What's the point? We don't ever really work with nurses." For midwives who do mainly homebirths or who always have a second midwife at the delivery, contact with nurses may be quite limited. However, all but one of the midwives I interviewed for this study said that roughly two-thirds of their deliveries are in hospital; that a majority of their clients want the capability for medical intervention in the background, but still close at hand in time and space, 'just in case...' This means that nurses and midwives inevitably interact in the hospital setting and that midwives' clients want the involvement of nurses and physicians in their care to be available to them if needed. But what does it mean to work together? Is working together a different experience than simply being in the room, for the same function, at the same time?

The work of perinatal nurses and midwives is the care of childbearing women, their babies, and their families during the perinatal period. To care for or about someone means to feel concern, interest or fondness for them. It is also to worry about, have caution for, and give serious attention to; to protect and look after (Simpson, 1989). In the context of human relation it evokes images in which those who care may show nurturing, tenderness, and protective vigilance. To bear something means to carry, show, or yield. It

also means to have responsibility for, and to endure (Simpson, 1989). Childbearing, to bear a child, incorporates the meanings of yielding, enduring, caring, and taking responsibility because it is a transformation to motherhood and family, not only at birth, but in life-long parental concern and love. In childbirth, caregivers bear witness to the phenomenal, fleshly, revelation of human relation in the advent of a child. They participate in women's bearing by their intensity in being-with them throughout this complex transformation; they bear women up with support and expertise, bear women's experiences out with responsibility and caring.

In my own experience as a perinatal nurse working in labour and delivery I have observed the responses of hospital-based nurses and community-based midwives to one another when midwives and their clients come into the hospital. In some cases, the midwife and her client have been shunned; that is, greeted coolly if at all, isolated, and grudgingly given detached assistance only at the time of birth, or on the rare occasion when there is an emergent situation. I have also witnessed warmth and respect extended to the midwife and her client, helpful interaction, and sometimes collegiality between nurses and midwives in the sharing of knowledge and experience. The sources of these different responses are complex. They lie in the individuals themselves, but also in the meaning and context of childbirth, and the epistemological understandings that underpin them.

There are several types of caregivers who experience relationships with childbearing women: nurses, midwives, physicians, doulas, family members and friends. Clearly all have a common concern and focus in the woman and her baby. However, each inevitably experiences this relationship somewhat differently depending on the

knowledge, meanings, professional or familial roles, and emotional nuances that dictate their words, actions and responses in the events of the childbearing process. For health care professionals, the knowledge and understanding brought to the care of childbearing women is the outcome of formal and informal education and clinical experience, as well as the particular socialization and comportment that is taken on in identifying with a professional group. Some of this knowledge and understanding that is brought into caring by different health care providers may form a shared grounding between caregivers, while some may not be recognized, or be differently interpreted. For physicians and perinatal nurses who work together there is much held in common. Not the least of which derives from the interwoven history of these professions, the shared epistemological models in which medical and nursing knowledge is based, and the common familiarity with the hospital setting and its institutional social structure. Perinatal nurses and physicians have some understanding of how each of them provides care and the expectations involved in their shared responsibility for childbearing women.

But, what of the relationship between community-based midwives and hospital-based perinatal nurses? Is there common ground here? Midwives are relative newcomers to the contemporary, legislated roster of perinatal caregivers. In Canada, they are educated in separate academic programs and have defined themselves as members of a healthcare profession independent of both nursing and medicine. However, the biomedical knowledge base they utilize is largely the same as that utilized by physicians and nurses. In addition, midwifery shares with nursing the gender predominance of women. Midwives are primary care providers for childbearing women, as family physicians are; but, like nurses, they are also 'bedside' care givers, providing care,

comfort measures, and emotional support while maintaining a continuous presence with women throughout labour, birth and the postpartum period. Given these general similarities between nurses and midwives, what generates the conflict and coolness that sometimes occurs between them as professionals? Are there clues in their ways of being with women? And if so how is this shown? The following birth stories help to illuminate these questions.

Two Birth Stories

A Hospital Birth

The young woman who told this story is early in her nursing career, but she realizes and takes hold of her expertise as a perinatal nurse. She is confident in her ability to care for childbearing women and to address their needs within the LDRP[1] Unit in a large tertiary care hospital where she works. She is comfortable in the hospital milieu, and seems to feel supported by her nursing colleagues and the physicians with whom she interacts. She tells about an experience in which her skills and abilities as a nurse contributed to a good outcome in the birth of a compromised baby.

> Something that has come up for me is how much of working in obstetrics is intuition. I can't tell you the number of times that I have been totally right on. It's amazing, you know? So here's an experience where intuition seems to have played a role.
>
> I had a primip [primipara; a woman having her first birth] who was labouring and things were going well but the head was really high, *really* high;

[1] LDRP (labour, delivery, recovery, and postpartum): Each woman receives care for labour, delivery, recovery and the early postpartum in a single, private room.

like so high I didn't want her to get out of bed. Do you know what I mean? It was freaky! And her water hadn't broken. Then eventually her membranes did rupture, it was a hind-water leak [high up on the membranes], but not a huge amount, and the presenting part came down, but not very far. It wasn't right in the pelvis. So, I said to the patient, "You can get up and go to the washroom, but I'm following you and I'm listening to the fetal heart. I'm just not comfortable." I had everything set up. So the waters were kind of leaking and clinically you would think – because it wasn't just a trickle, it was a decent amount of fluid – that probably it would be okay to just rupture the membranes [in front of the baby's head]. That's what ended up happening: the physician ruptured the membranes and when he left the room initially it was okay, but in fact he had prolapsed the cord. It was an occult prolapse so the doctor couldn't feel it when he was examining her.

I forget how dilated the patient was with the ARM [artificial rupture of membranes], but her husband was going to get something to eat. She had an epidural and was lying in bed on her back. It was kind of downtime so that's why the husband was going to go. At that point there hadn't been a contraction since the ARM. But then when she did have a contraction we got this great big, scary deceleration [in the fetal heart rate]. So, I got her to flip over and gave her oxygen. I was trying to remain calm. I rang the call-bell right away and said, "I need another set of hands in here. We've got a deceleration." And so another nurse came in and I said, "Call the doctor! Get the doctor back!" He was in the house, which was great, and he came right back and assessed the situation. By this

time she was fairly progressed, about eight centimeters or something. And he was trying to see if maybe the cervix would go but there was no way. So he just said, "We've got to go now!" And I'm trying to reassure the patient, "Okay, we just need to take you to the OR [operating room] now." I got the consent signed, got everything done, got stuff going. You're doing it all at once. It's just unbelievable how scary that can be. We got her over into a knee-chest position and it relieved the fetal heart somewhat. And actually by the time we got her to the OR the fetal heart had recovered. But it was one of those 'unplug-the-bed-and- run-down-the-hall' kind of situations. I hadn't had an experience like that before where it was critical to get to the OR so quickly. You know, typically when there is fetal distress they hem and haw and it's not such a panic. *This* was a *panic*! (Jenna, perinatal nurse)

In this nurse's story she elaborates her understanding of the way in which intuition guides her practice as a perinatal nurse. However, her words also demonstrate the considerable obstetrical knowledge she utilizes in everyday practice, and her comfort in the hospital obstetrical milieu. She speaks of the 'head,' the 'pelvis' 'membranes,' 'water,' and the 'cord.' These abstractions scattered throughout her description make up a collage of sensations and relationships between recognized shapes, textures, and substances that gave meaning in the context of her patient's labour. As she describes, the woman's amniotic membranes were leaking enough fluid that she worried about an umbilical cord prolapse, particularly if the fore-waters, the portion of the amniotic sack in front of the baby's head, were to burst. The release of fluid might cause a loop of cord to slip down and wedge tightly between the baby's head and the bones of the pelvis, or

worse, to slip out through the cervix in front of the descending head. In either situation, the cord would be pinched by the force of the contracting uterus, cutting off oxygenated blood flow to the fetus. In this case, initially everything was going well, the fetal heart was reassuring; however, reasoning from her knowledge of the process and the parameters of best practice the nurse was careful in allowing her patient to take an upright position where gravity might cause the umbilical cord to prolapse. In addition, she felt an involuntary concern and wariness in regard to this patient, a concern that was strong long before the physician, thinking it was prudent, ruptured the fore-waters.

Labour progressed. The fact that it was mediated by technology and pharmacology seems taken for granted in this story; yet without use of these powerful tools by physicians and nurses this story's outcome would have been very different. The anesthetist inserted an epidural. The woman's physician visited and with a simple sterile instrument artificially ruptured the fore-waters. The nurse listened to the fetal heart with an electronic auscultation device. She heard the galloping heart tones, the technologized sounds of the baby's heartbeat relayed by a fetal monitor. Perhaps she shifted her gaze to this monitor and watched as the upper and lower tracings continuously spilled out onto the graph paper a translation from the transducers strapped to the labouring woman's abdomen. The upper cardio line traced out the zigzag of the fetal heart, and the lower toco line revealed the mountains and valleys of the contraction pattern. She may have watched the toco line ascending the slope of the next contraction and instantaneously reacted with a jolt of adrenaline as with it she simultaneously heard and saw on the graph the fetal heart rate plummet.

In this account, while the nurse does not describe her relation to the woman and her baby, her focus and actions in this crisis, the decisive directions she gives to the mother in order to initiate intrauterine resuscitation of the baby, demonstrate the responsibility that enlivens her care. The woman's cooperation is absolute and unquestioned in response to the nurse's urgency suggesting a tacit understanding between them that safety of the baby is the primary concern in this situation. The nurse relies on her physiologic knowledge of birth and her nursing practices to bring about a safe delivery. Perhaps what she calls intuition in this story is really how nursing enacts its practices in the fluid synthesis of moment-by-moment assessment and with instantaneous artful action (Cameron, 1998; MacLeod, 1996).

> My co-workers were fantastic. They really helped me out. And one of my co-workers came with me. What I found hard was to see my patient under a general. I have never established a relationship with somebody when they were in labour and then seen them like that. I couldn't be with her when she was being put out; it was just so upsetting to me. So it was great; the nurse who came with me didn't know her and was able to take over that role and I did more to prepare for the baby and get everything ready. It worked out fine. The baby was great and mom was fine. When I reflected on it at the end of the day I thought, "You know, I just knew it." I was really very thankful to the other nurse who came and helped me out. And she said, "Well actually I didn't do much. You knew something was up and you had it right on." So it was kind of neat because I got that recognition too. (Jenna, perinatal nurse)

The nurse states that to see her patient anaesthetized would be upsetting. Why might this be so? Perhaps it is the deathlike estrangement that occurs when someone who was lively and responsive rapidly becomes inert, their independent vitality rendered in need of technological support. The woman, with whom the nurse had established a brief but intense relationship in working with her toward the birth of her child, was seemingly gone, though the pregnant body still demanded attention. She was relieved when a co-worker took over the nursing care of her patient. With the prolapse of the umbilical cord, the nurse's attention turned appropriately to the welfare of the baby. She continued to focus on this site of hopefulness with all of her concentration and effort.

We know little about this woman and her husband from this account and nothing of their feelings in this potentially frightening situation. However, the nurse notices a change in her the next day.

> And so the next day I went in to talk to this patient and she was very...kind of shut down about it. I didn't feel a real rapport the next day, which was kind of strange. I think she was just dealing with her stuff. (Jenna, perinatal nurse)

The lack of rapport this nurse experienced with her patient could have many causes. The woman would have been tired and, following surgery, in some discomfort. Though we are not told of the woman's expectations for her birth, it is possible that she was processing a welter of feelings at becoming a mother and not having had the birth she anticipated. She had little choice and control over her experience due to the circumstances that endangered her baby. The nurse found the lack of connection between herself and the patient unexpected and strange. However, as nurses often do when verbal communication is absent or lacking, she speculates about her patient's state and the

distance she experiences between them. Is the 'stuff' she speaks of the emotional detritus that can be left following events such as this emergency caesarean section? Often such imaginative reconstruction, combined with what can be gleaned about a patient through embodied senses is all that a nurse has in the moment as the basis for inviting relation.

Though it is probable that the majority of women this nurse attends have relatively straightforward and uneventful births, she cares for women in a manner and in a setting that anticipates the potential danger and trauma of labour and birth. Nurses know that medical expertise, analgesics, epidurals, surgery, and a neonatal intensive care unit are available to their patients, and that they are never alone should things go awry. Their patients know this too, and no doubt most choose hospital births for this very reason. There is a justifiable protectiveness in a nurse's watchful care, which operates from a premise that she knows what to look for and can read her patient in a way that the patient cannot read herself.

A Home Birth

The midwife who tells this story came to her chosen profession after the births of her own children. She learned her skills primarily through apprenticeship with other 'homebirth' midwives. In this account the midwife describes an experience she had while working as a 'homebirth' midwife, shortly before she and other midwives in British Columbia were legalized and regulated. At that time, all of her prenatal and postpartum care and deliveries took place in her clients' homes except when there was a particular need to seek medical assistance at the hospital; so, this midwife's experience was largely non-institutional.

This is a good story. I always tell this to people who say you shouldn't have children at your birth, because this was a wonderful birth that involved a whole family. It was a planned home birth. This couple had three children, their fourth child was stillborn. So this story is about the birth of their fifth baby; their fourth living child. All three children were there along with the children's aunt. The youngest was about three and the oldest was around eight. (Leona, midwife)

It is significant that the couple in this story, who suffered a stillbirth with their last pregnancy, chose midwifery care and a home birth. Apparently they did not find it necessary to attend to the 'what ifs' related to the woman's now risk-prone obstetrical history, which typically, within the medical obstetrical practice, would have lead to a highly monitored pregnancy and hospital birth. The midwife who was responsible for care also did not consider that hospital-based surveillance of this labour and birth was necessary. Their choice was to share the birth experience with one another and their children in the context of home, the place where family is defined and experienced by its members.

I was the second midwife, so when I arrived the woman was busy having contractions and wandering around the house. My partner had set everything up in the bedroom because that's where the woman said she wanted to give birth. Women at home seldom give birth where they say they are going to. For this reason we always put everything, our supplies and equipment, onto a cookie tray so that we can move it to wherever the woman actually is. So meanwhile the mom was labouring. The children would come in now and then. They had some videos to watch and things to keep them busy while they waited, and they were baking a

cake for the baby with their aunt, a birthday cake. They were just wandering in and out. Every so often the little one, the youngest, would sort of bend down and check to see if something was actually happening between her mom's legs. No, nothing happening, so off she would go again.

About an hour and a half after I arrived labour started getting intense and it was obvious that the birth was about to take place. So we let the aunt know that the kids should probably come in now, because it looked like the mom was about to push; and we knew she wasn't going to push for very long. When she started pushing her husband said, "Well, do you want to go to the bedroom now?" "No, I'm going to do it right here." Okay, so I'm the second, the second is always the 'gofer' and I was rushing to get everything back into this room. Luckily, as I say, we keep everything on a cookie tray so it's really easy to move. So I picked it up and moved it so we had all our primary kit there. No problem; it's just the oxygen and the resuscitation stuff that you have to find the right place for. So we moved everything, and the three kids sat in a chair on the other side of the room where they could see what was going on. And the woman basically just leaned over against the chesterfield and gave birth standing up. That's what she wanted to do. My partner caught the baby. The mom goes, "Oh how gorgeous!" She turns around, sits down on the chesterfield, takes her baby, and the kids come over to look at the new baby with their parents. Finally the youngest one says, "Can we have cake now?" The aunt says, "No because it's not iced, but we'll go ice it." So the kids go off and ice the cake. Mom and Dad have a little bit of quiet time together. We monitor and everything is fine. Then we have the birthday cake and

we all sing 'Happy Birthday.' It was really nice! But as you can see, it's quite different from much of what happens at births now. (Leona, midwife)

Birth in this story was a part of life; part of the flow and rhythm of a growing family. It was a happy, exciting, family-focused event like a birthday party or religious holiday celebrated at home; not an emergent or a traumatic event where medical obstetrical knowledge and technology played starring roles. These scientific accoutrements were there, in the background, along with the midwives' knowledge and judgment in the use of oxygen and resuscitation equipment, as well as their vigilance; but 'Obstetrics' is not a hero in this scenario. The central characters here are the woman, fully embodied in labour within her home-space, her awaited child, and the family members whose lives will be transformed by this birth. The midwives are there, but only as facilitators in an event that the woman herself orchestrates according to the direction of her body.

The placement of equipment and supplies on a portable cookie sheet provides a wonderful metaphor for the place of medical knowledge in the context of this home birth. The cookie sheet, a common kitchen utensil used to cook food and desserts, things that bring family members together to nourish and give them pleasure, supports the implements needed for assessment and prudent care. This homely domestic item allowed the labouring woman to move freely about in her own environment, and to choose the exact location where she bore her child. She was not required to come to these implements and supplies as would be expected if the hospital had been her chosen place to birth. This cookie sheet laden with the midwives' kit was like the home itself, which, as the site of childbirth, supported all that took place through its familiarity, comfort and

protection. Any exigencies that might have called for medical intervention were first held and under-girded by home, the place of day-to-day interactions with family, intimacy and love. The couple and the midwives understood birth as belonging in the home where the matrix for human relationship is shaped by family life. Preservation of the relation between the mother, baby and family were paramount. All else, including the possibility of obstetric emergencies, was submerged beneath the primacy of maintaining the integrity of these relations within the home-space. As this woman demonstrated, home was the place where she felt confident and safe; where her family was welcome; where her children were with and reassured by their parents, yet were also creatively amused and happily supervised. Home was the place where her new baby may well have been conceived; where, perhaps, her last child died; and where she and her husband could participate together, uninhibited, in welcoming this new life.

In this story, in addition to the place of birth, the role of the midwives and their relationship with the woman and her family are important. The fact that the midwife who relates the account speaks little of herself or her midwife partner indicates a focus on the woman as choreographer. She moves about the house freely to the rhythm of her contractions and chooses the location for the baby's appearance. She is the person to whom authority is given in what is a relatively easy labour and birth. This suggests that she and her midwives knew one another well and had an established basis for trust that allowed all involved to treat this birth as a natural process with confidence that should anything untoward happen the caregivers were present to take action and offer support. The midwives were observant and knowledgeable enough of the woman's body and the physiologic process of her labour to anticipate a rapid, easy delivery, yet the woman is

spoken of throughout as a whole person situated within the web of relationships woven between all those who were present. How might this story have been different if there had been fetal distress or a problem with the progress of labour that necessitated rapid transport to the hospital? Would the midwives' role have changed? In turning care over to other obstetrical experts would the woman's relationship with the midwives have intensified as they changed their focus to providing her with information and support in an un-home-like environment?

Juxtaposition: Locating the Problem

The nurse and midwife participants who related these two birth stories did so in response to being asked about experiences of caring for childbearing women that were vivid for them and in which they believed they made a difference to events in some way. It seems that each participant chose an exemplar story to tell in that the accounts reflect many taken-for-granted aspects of the care they provide to women within the contexts of their beliefs about and philosophies of birth, formal and informal epistemologies, professional preparation and ethos. It is important to note that most hospital births under the care of nurses and physicians do not involve circumstances that require emergency caesarean section, but proceed to a vaginal delivery. Likewise, not all midwifery births are as easy and uncomplicated as the story presented here, nor do they all occur at home. Although the two births described are very different, it is perhaps meaningful that these stories are those that stood out for the two participants. The juxtaposing of the stories reveals both similarities and differences between the work of the nurse and midwife narrators. The midwife and nurse share the same knowledge of the physiology and

mechanics of the birth process, the same assessment skills, and the same knowledge of pathology associated with labour and birth as well as the immediate actions to be taken when it occurs. However, the nurse works in an environment that is shaped by and anticipates pathological occurrence and where it is assumed that many if not most women will require some assistance through the use of pharmacology and/or technology to birth safely. Whereas the midwife, who at the time of her anecdote primarily assisted women to birth at home, assumes that women are able to accomplish the work of childbirth with minimal assistance and that, though prudent vigilance and preparation are practiced, untoward events are relatively rare. Given the similarities and differences shown here, what is it like for midwives and nurses to interact and work together in the care of the same women, as happens when midwives' clients choose or need to be admitted to the hospital? How might nurses and midwives recognize those practices, knowledge and assumptions that are common, and negotiate the differences in approach and understanding, in order to provide safe and satisfying experiences for women and their families? Might the similarities be experienced as a basis for solidarity and support; or would they be a source of judgment, competition and rivalry? Would differences be held as a cause for anxiety, contention and prejudice; or could they become the basis for dialogue and mutual learning? In order to understand the answers to such questions it is necessary to turn to the lived experience of perinatal nursing and midwifery, as well as the experience of interaction between individuals of these groups of professionals.

Problem and Mystery

The two stories and their analysis above show a hospital-based nurse and a community-based midwife phenomenologically, as self-constituted agents each within a social milieu; individuals in particular contexts, and in relation with others (Burch 1991). Their potential interaction with one another suggests a problem or puzzle related to the nature of their similarities and differences. What might their interaction be like and how might it be facilitated? To identify a problem assumes that concrete answers can be found which describe and address it. In fact, the problem of interaction between nurses and midwives has been described politically (Bourgeault & Fynes, 1996-7; Kornelsen, Dahinten, & Carty 2000; McKendry, 1996-7; Sharpe, 1997), structurally (Kornelsen, 2000; Lyons & Carty, 1999), theoretically (Kornelsen, 2000; McKendry, 1996-7), and relationally (James & Pauly, 1999; Kornelsen, Dahinten & Carty, 2003) in the literature as a frequently tenuous, unpredictable, and sometimes hostile relation often complicated by misunderstanding and misinformation. It has been less frequently described as contributing to evolving relational collegiality (Kornelsen, Dahinten & Carty, 2003). Given this, logical concern is generated that the nature of this relation – in particular its negativity – may lead to unethical, uncaring, and dangerous interprofessional situations for childbearing women.

Approaches that dictate the division of responsibility in shared work, and the maintenance of checks and balances to ensure that women are not harmed, can be superimposed in the form of institutional policies and protocols to follow when there is disagreement or uncertainty. However, such answers to this problem do not address it at its roots; that is, in the substance and ethics of relation. Relevant to and underlying this

problem regarding the interaction between nurses and midwives in their work with childbearing women, are deeper questions that constitute not so much a *problem* for which 'correct' answers are sought through factual or theoretical analysis, as a *mystery*, which can only be explored through existential experience. That is, the mystery of relation itself and the ethical dimensions that facilitate its growth and positive capacity, even in the face of barely comprehensible difference.

Burch (1989) suggests that a problem "concerns...how we can better deploy the various 'objective' realms that our theoretical, scientific, and practical activities posit". For problems we "seek the correct information" (p.7). Likewise Marcel (1950) says that a problem "is subject to an appropriate technique" (p.211). A mystery on the other hand, "by definition, transcends every conceivable technique"; it is "something in which I myself am involved" (Marcel, 1950, p.211). The 'I' at the centre of the mystery of relation is the 'living I' (Bergum, 1994), the person who's lived experience encompasses the mystery. In the case of this study, the 'I' of each nurse and midwife in relation with one another and with childbearing women, their babies and families. Burch (1989) suggests of such a mysterious phenomenon that "we do not so much have a question, as we *are in it*" (p.7). It is impossible to be at once in relation and removed from it as it is an enveloping and profoundly human experience. It is a mystery into which the more deeply we enter – or let it enter us in our being – the less we can keep an objective or theoretical purchase upon it. In relation, we cannot know the mind or substance of another without seeking to understand them as they reveal themselves; not as we might think to label or categorize them. This mystery then is both apprehended and experienced by seeking "not a definitive answer, but an ever more radical and comprehensive context of

understanding... 'the elucidations of meaning'" (Burch, 1986, p.7). What are the meanings that others reveal to us in being themselves?

This differentiation between problem and mystery, then, is relevant to this study as it suggests a mode of inquiry; that is, to seek understanding of the meanings shown in actual experiences that illuminate the mystery of interprofessional relation. This would include the taken-for-granted meanings that the participants themselves may not identify because they are elements of their being as nurses and midwives. Forms of inquiry that seek categorical description and measurement would only allow for the identification of abstract factors influencing interaction. These might facilitate structural change or the development of theoretical answers to address problematic relation. However, relation as mystery cannot be legislated or imposed. It can only grow through understanding of self and of other. In lived relation between nurses and midwives advantage can be taken of problem-solving strategies, but these are unlikely to sustain relation unless individuals begin with a willingness to open to the mystery of the other (Bergum, 1994). In other words, what is called for is a means to discover a relational ethic; a moral way of being with others that facilitates insight into, and respect for, the uniqueness of the other's embodied self: woman, baby, nurse, and midwife. To relate ethically presupposes a turning toward the other, a willingness to understand something of their way of being and of what is significant to them (Bergum & Bendfeld, 1999; Irigaray, 2002). The purpose of this research is to facilitate such ethical relating. By showing something of the meaning in nurses' and midwives' interactions with childbearing women and with each other, and the meanings of birth illuminated by their words and experiences, their mutual

understanding can be deepened and insight provided into ethical collegiality in interprofessional practice

Research Questions

In summary, the phenomenon of interest for this study, the mystery to be explored and understood, is the experience of relation. Two groups of caregivers are the focus, hospital-based perinatal nurses, and community-based midwives. The roots of my interest in this topic are planted deep in my own experiences of medically mediated childbearing, as well as my experience as a perinatal nurse working closely with childbearing women. As described in the beginning of this chapter, I have observed uncertainty and antipathy in some hospital-based nurses toward community-based midwives and have wondered about its meaning. Values, assumptions, expectations, comportment, and modes of relating to patients or clients seem to be common to members of specific professional groups, learned through immersion in the language, theoretical discourse, and context of the professional milieu. Looking beneath these conceptual structures at nurses' and midwives' experiences, what is shown about the meaning of participating in childbirth as a caregiver? How is the ethos, the moral character, of these professionals revealed? Is there common ground in their practices and meanings? And can this ground be a shared space of fertile understanding, rich and expansive enough to encompass difference? Can it help facilitate safe and satisfying childbirth experiences for women who choose midwives as primary caregivers but come into medical institutional contexts to birth?

The research questions explored in elucidating the lived experience of nurses and midwives in practice with childbearing women and in interaction with one another were

the following: What are the meanings of relation shown in hospital-based nurses' and community-based midwives' experiences of caring for childbearing women? What are the meanings of relation shown in their interactions with one another as caregivers? What are the relational meanings of birth?

CHAPTER TWO

INVOKING THE LITERATURE

This study illuminates themes of relation in the healthcare setting between two different groups of professionals, nurses and midwives, and between these caregivers and the women and babies whom they serve. Before entering into the participants' lived experiences of relation, this chapter helps to situate us through a review of the literature within the larger frames of reference formed by the contexts for, and epistemological understandings of, childbirth within which nurses and midwives enter into relationship with women and one another. Review of the research on nurses' and midwives' interactions with women and with one another is also presented. In addition I will explore more generally interprofessional interaction and collaboration in the healthcare context, to which the shared care experiences of nurses and midwives contribute. First, however, the meaning of ethical relation, a deeper understanding of which is sought in this study, is explored.

Relational Ethics in the Healthcare Context

Relational ethics are, as the term implies, based in the immediacy and engagement of relationship between individuals. In health care situations relational ethics offer a way of acknowledging "the rich complexity of actual human relationships" and recognizing "the moral significance of the actual ties that bind people in their various relationships" (Sherwin, 1992, p.49), which are enormously significant in situations of birth, death, and illness where other taken-for-granted aspects of the world, even our bodies, are thrown

into strangeness (van Manen, 1998). They are a "practical, context-specific approach to ethics" (Sherwin, 1992, p.80) that does not negate or disregard professional ethical commitments or other strongly held ethical theoretical approaches such as principle-based ethics, utilitarianism, virtue ethics, or objective, rational approaches. Rather, they encompass these as they have meaning for individuals within the specific context of the interpersonal relation without allowing the absolutism of ethical theory to dominate or oppress. Bergum and Dossetor (2005) describe relational ethics in practice as,

> [...]the way persons are with one another in various roles: as healthcare practitioner, patient, team member, teacher, student, parent, neighbor, as well as friend. Such a focus attends both to who one is, as well as what one is or does as we live ethical action moment by moment. (p. 3)

An examination of the healthcare focused relational ethics literature gives insight into how relational ethics are lived in the context of caregiving.

Bergum (1994), Bergum and Dossetor (2005) and Gadow (1992, 1994, 1995a, 1995b) write about types of knowledge and the construction of knowledge for ethical healthcare in the context of the relational ethics discourse. They use similar and related concepts to describe relational ethics between the caregiver and person/patient. An integral concept that all share is the notion of 'inherence' (Bergum, 1994; Bergum & Dossetor, 2005; Gadow, 1992). Bergum (1994) defines inherence in the context of healthcare as "that lived wholeness experienced from within rather than surveyed from without; it gives personal meaning to the events of health and illness; it includes the descriptive knowledge of personal symptoms and the abstract knowledge of scrutiny and analysis" (p.73). Gadow (1992) speaks of inherence as "that personal meaning that will

organize otherwise meaningless data" (p.598). That is, inherence takes into account the person's subjective experience in the moment, the abstract clinical knowledge of biomedical diagnosis and treatment, and the awareness of the person as a holistic entity, and integrates them within the lived experience and personal meanings of the individual (Bergum, 1994; Gadow, 1992, 1995a).

These authors describe the means of achieving inherence, and for all it is through relationship. Bergum (1994) proposes three shifts within the relational context that move the caregiver and person toward a place of inherence. The first is the move from dominance to collaboration. Meta-theoretical ethical knowledge is dominating in its attempt to seek universal approaches that generalize human experience and make presumptions regarding correct ethical action. However, relationally ethical knowledge that focuses on the individual and their complex experience of the world cannot presuppose appropriate action but waits for it to be discovered in relational collaboration between those involved. The second shift is from abstraction to context. Abstract knowledge, such as much scientific and medical knowledge, reduces and fragments, necessarily viewing individuals as separate from their particular, subjective and intersubjective context. Decisions and action based in this type of knowledge can be coercive relying on the power accorded to this knowledge in our society and institutions. Inherent knowledge based in relation grounds abstract knowledge in the broader context of the personhood of the individual. The third shift toward inherence is the move from beneficence to nurturance. Beneficence is unilateral action, "doing good in another's best interest" (p.77). Nurturance is reciprocal and moves beyond beneficence to "strengthen and support each person's ability to choose what is best 'for his or her own good'" (p.77).

Nurturance occurs in mutual participation between the caregiver and person. The caregiver does not seek a predetermined outcome for the person but offers an embodied presence and support, accepting the responsibility that accompanies relationship with the other. Nurturance "is the place where hope resides, where healing is sought, and where we remember what the person can become" (p.78).

Gadow's understanding of the concept of relational inherence evolves throughout her writing. She most frequently implies it in terms of its means of achievement through two other concepts, the 'relational narrative' (Gadow, 1994, 1995a, 1995b, 1996), and 'engagement' (Gadow, 1995a, 1995b, 1996). The beginnings for this notion of inherence can be seen in her early writing about 'existential advocacy' as the philosophical foundation for nursing practice (Gadow, 1980). Existential advocacy involves the caregiver's respectful facilitation of the patient's self-determination, an embodied involvement that engages the "entire self of the nurse" (p.97), and assisting the patient to integrate the subjective experience of the "lived body" with the "object body" by which she or he is identified by biomedical science (p.92-97). The importance of the embodied presence and subjectivity of the nurse is elaborated in her exploration of existential advocacy with silent patients (Gadow, 1989). The relational narrative as a means to relational inherence is the intersubjective story that is constructed by individuals in relation allowing them to make sense of the phenomena that confront them in lived experience. It recognizes the meta-narratives of science, medicine, gender, and social convention but does not privilege them, rather incorporates them as they have meaning in the lives of the individuals involved (Gadow, 1994). In the healthcare setting the relational narrative is constructed by the person and caregiver together to give existential

meaning to the experience of pain, vulnerability, diagnostic labels, and relationship (Gadow, 1995a, 1995b). It is, in a sense, the story authored by relational inherence. Engagement is the action that brings inherence into being and allows the relational narrative to be told (Gadow, 1996). It is the intersubjectivity between caregiver and person/patient within which meaning is forged and identified (Gadow, 1995a, 1995b). Engagement is beyond the control of generalization and the universal; it "epitomizes contingency" as the relationship between two unique and particular individuals (Gadow, 1995b, p.9).

Cameron, another nurse scholar, shows inherence, though does not label it as such, and ethical relation in nursing in her phenomenological exploration of nursing and its practices (1998) and in the significance of the nursing 'how are you?' (1992, 2004). She develops this work further in a philosophical examination of how in giving care, the nurse demonstrates the seamlessly interwoven nature of the 'presentable,' theoretical knowledge, in the 'unpresentable,' the aesthetic, pre-reflective, relationally ethical practices of the nurse. This is accomplished through the nurses embodied, relational knowledge, involving attunement and engagement with the patient, in combination with her personal knowledge; that is, through inherence (Cameron, 2006).

A conscious living out of ethical relation, or inherence, is integral to best nursing and midwifery practice as it is for all healthcare providers. How do nurses and midwives experience inherence in relation with childbearing women? And what meaning does ethical relating have in their interactions with one another? These themes are taken up later in this study in the hermeneutic description of participants' experiences.

Theoretical and Philosophical Bases of Perinatal Nursing

The body of theoretical knowledge utilized in the specialized area of perinatal nursing is vast and beyond the intent of this review. The interest here is not in specific physiological or psychological theory but in the theoretical foundation that gives shape to the relational aspects of perinatal nursing practice. Perinatal nursing finds identity and context within the medical model of healthcare. Barbara Katz Rothman (1996) suggests that this model is altruistic and caring, but disempowering of women. The aim of caregivers within this model, she says, is to manage and control childbirth for the good of mother and infant. "When we 'manage' birth we are after all, managing people. To control a situation or an event is to control the people and to control is to take away power" (p.253).

An examination of current perinatal nursing texts and literature reveals that theory and tenets relevant to the nursing relation suggest that this disempowerment is not intentional; quite the contrary. A focus on family-centred care that encompasses diversity, and a holistic view of women, that takes into account individual physical, mental, emotional, social, and cultural factors is common (Lowdermilk, Perry, & Bobak, 1999; Ladewig, London, & Davidson, 2006; May & Mahlmeister, 1994; Simpson & Creehan, 2001; Tomlinson, Bryan, & Esau, 1996). Phillips (1998) defines the nurse' role in family-centred care as one of preserving childbirth as a normal wellness event and promoting the mother and family as the infant's primary caregivers (Zwelling, 2000). Even classic views of the mechanisms of labour have been updated to accommodate a more individualized, women-centred view of the birth event. For example, the 'three Ps'

of labour, *passenger, passageway*, and *powers*, have been revised to include the *psyche* or psychosocial influences within the labouring woman (Lowdermilk, et al., 1999; May & Mahlmeister, 1994; Ladewig, et al., 2006; Vande Vusse, 1999), and the *position* of the woman during labour (Lowdermilk, et al., 1999; Vande Vusse, 1999). Vande Vusse (1999) proposes, based on an analysis of 33 women's birth narratives, that there are other forces, other 'Ps', influencing women's labours that should be taken into account. Among them are the "professional providers", the "place of birth", the "procedures", and the "politics" of the situation, all individually, relationally, and contextually relevant factors (p.179-180).

Though this intention to shape practice around the individual woman and family is present in texts used to guide perinatal nursing practice, a focused description of the possible experience of relationship between the childbearing woman and the nurse is missing. How can individualized care occur without positive relation at its core? Woods (1995) and Condon (2002) address the issue of relationship between nurse and woman within a holistic feminist framework in for women's healthcare providers. Woods (1995) says that "[t]he focus of the relationship is on the woman as a person, her 'self' as she defines herself in the context of her lived experience" (p.136). Its elements are "[m]utual recognition of one another's expertise, sharing of information, and defining goals in collaboration" (p.135). She defines the nurse's acts of caring as being comprised of the following: seeking the meaning of the healthcare event in the life of the woman; being emotionally present; enabling her to accomplish transition through the event, as well as doing for her those things that she would, but cannot, do; and believing in her capacity to accomplish what the event demands of her. Likewise, Hunter (2002) explores the

concept, 'being with woman,' in the nursing and midwifery literature identifying 'presence' and 'social support' as relevant sub-concepts substantially represented in the perinatal nursing literature. This too contradicts Rothman's (1996) critique of the care of childbearing women in the medical context within which perinatal nurses work. A further look at the research literature demonstrates more of what the nature of perinatal nursing practice is, how and whether these theoretical and philosophical bases are manifested.

The Nature of Perinatal Nursing Care

Nurses' experiences of caring for childbearing women have been little studied. However, the existing research has focused primarily on the nursing interaction with women and on technological and institutional aspects of giving perinatal care. A number of descriptive studies provide some insight supporting Rothman's (1996) claims. What these studies show is the desire and conscientiousness on the part of perinatal nurses to be supportive to patients, and also the ways in which this support is circumscribed and inhibited by institutional and medico-technical influences.

Using a social constructivist theoretical approach, Beaton (1990) analyzed verbal interactions between nurses and labouring women according to Stile's Taxonomy of Verbal Response Modes. Verbal exchanges were examined for attentiveness, acquiescence, and presumptuousness according to their grammatical form, intent, frame of reference and focus. Nurses were found to be most attentive to women when offering comfort care and least attentive when monitoring equipment, doing vaginal exams, and giving medications. Women were not highly attentive to nurses throughout, even when being coached by them. Beaton (1990) states that acquiescence is an indication of "whose viewpoint or definition of reality predominates" (p.401). In interaction, neither nurses nor

women acceded; rather each attempted to control exchanges by "keeping within her own frame of reference" (p.401). During coaching "...the nurse attempted to maintain control of the patient and the situation by ignoring the woman's comments and focusing on the task at hand, thereby defining the situation in terms of her own perspective" (p.403). Likewise, in terms of presumptuousness, nurses were highly presumptive of the woman's experience and viewpoint. However, they were least presumptive when offering comfort or when simply conversing with women about topics unrelated to care. Beaton (1990) states that verbal forms used by nurses did not vary much from nurse to nurse or in relating patient to patient. In other words, women were treated as generic patients and nurses used routine communications. Nurses were focused on problem solving, protocol, and efficiency rather than women's experience. The author concludes that, in practice, nurses do not offer family and patient-centred care; rather care is based in nursing or institution-centred philosophy. The individual perceptions and experiences of the women and nurses in this study were not explored. In addition, what allowed nurses when offering comfort measures or engaging in simple conversation to be less presumptive and controlling was not examined.

Two other studies also using conversational analysis techniques as well as video taped visual data during the second stage of labour provide similar pictures of nursing care (Bergstrom, Roberts, Skillman, & Seidel, 1992; Bergstrom, Seidel, Skillman-Hull, & Roberts, 1997). Though the caregivers in these studies were not all nurses, the second study (Bergstrom, et al., 1997) shows aspects of nursing care that demonstrate greater dimension in the nurse/patient relationship than is seen in Beaton's (1990) study. For example, the difficult position nurses are often in when trying to balance the woman's

needs with social and institutional constraints during stressful situations is clearly portrayed.

In the first study (Bergstrom, et al., 1992) the authors observed that vaginal exams were routinely done on women, often very frequently, during the second stage of labour generally causing a great deal of distress for the labouring woman. On the premise that caregiving styles and setting for labour are culturally determined and effect the ways in which childbirth is managed, the researchers videotaped 23 women and their caregivers during the second stage of labour in two large North American hospitals to examine what typically transpired. Two types of vaginal exams were noted: one to guide and assess pushing efforts; and another to assess the position and descent of the fetal head. This second type was particularly uncomfortable for women. Two themes emerged from this study regarding caregivers: first, "that the examinations can be seen as a type of health care ritual, accompanied by personal disembodiment of the caregiver"; and second, "that they [vaginal exams] communicate an overall message of the power of caregivers over the laboring woman" (p.16). In these sequences women were not warned about the discomfort they might experience and their responses such as "screaming, pleading, cursing, crying arching the back, pulling the head backward, and panting" were ignored by the examiner (p.15-16). Results of the exam were not shared with the woman herself but rather with other attending caregivers. Nurses, who were in most cases assisting and not performing the exams, often offered the women coping approaches but did not advocate on their behalf. The authors conclude with four recommendations for caregivers: decrease the frequency of exams during second stage; negotiate with the woman when an exam is necessary; inform women about possible discomfort and pain,

and apologize when causing it; and become re-embodied, that is, present enough to share in the woman's vulnerability.

The second study (Bergstrom, et al., 1997) analyzed audio and video recorded data of three women and their caregivers from the first study that was captured before the second stage of labour had 'officially' been confirmed. In these three cases each woman had a strong physiologic urge to push but was inhibited from responding to the urge until the correct professional caregiver pronounced her cervix to be fully dilated and gave her permission to push. Although the women's agitated behaviour and emphatic verbalizations clearly stated their desires and involuntary bodily responses, these were discounted. The nurse attending the woman in each case played an important role in enforcing the 'don't push' rule based on the strict criterion defining second stage. In the second two cases the nurses were also clearly distressed at having to observe social and institutional expectations that required certification of second stage by a specific, and slow-to-arrive, physician; and yet they did so while trying to support and offer encouragement to the distraught women in their care. The authors observe, "caregivers who ascribe to the rule find themselves in a crisis situation that they are taught has to be 'managed.' The laboring woman is the person who must actively modify her experience to bring her behavior in line with what 'ought' to happen" (p.179). This report ends with an appeal to caregivers to listen and take seriously what women say about their experience, acknowledging that it is by their active efforts that babies are born, not by the correct implementation of a theoretical script for labour. Though nurses are not the primary focus of these two studies, insight into their roles and the context of practice is evoked in these scenes from second stage labour. Hodnett (1997) submits that the effects

of being part of an institutional structure are difficult for nurses to override. She argues that there is considerable peer pressure to conform to norms of care as they are typically practiced and that nurses who deviate risk being "shunned, set apart, and even ridiculed" (p.79).

Another view of the nature of perinatal nursing practice is provided by McNiven, Hodnett, and O'Brien-Pallas (1992) who conducted a work sampling study of labour and delivery nurses in a large Toronto teaching hospital. A random sample of 384 observations of labour and delivery nurses at work were taken using two scales, one for recording supportive direct care activities, and another for recording all other direct and indirect care activities plus meal breaks. The results showed that an average staff nurse spent 9.9% of her time in supportive care made up of instruction/information (6.65%), emotional support (2.6%), physical comfort (0.3%), and advocacy (0.3%). All other direct and indirect care, and meal breaks, took up 90.1% of the time. Much of the other care was taken up in "technological tasks" (not defined) (p.7). The authors conclude that nurses work in an environment that values intelligence, decisiveness, and lack of emotion associated with technological tasks, and where supportive, interpersonal care and "connection between individuals" are undervalued or unrecognized (p.7). They acknowledge that support is more complex than can be measurably observed so that it may have been present in ways that were not detected in this study. The experiences and perceptions of support on the part of the nurses and women involved were not explored. Similar results regarding a small percentage of time spent by nurses in labour support were found in a subsequent work sampling study conducted at a site in Quebec (Gagnon & Waghorn, 1996). Like the previous studies discussed, this research suggests that

perinatal nursing care of childbearing women is frequently not woman- or family-centred, nor conducive to supporting women's capacity for a satisfying birth experience.

Gale, Fothergill-Bourbonnais, and Chamberlain (2001) conducted a more recent work-sampling study in a large tertiary centre in Quebec. Four-hundred and four observations of nurses caring for labouring women were recorded and categorized as either "supportive care" including physical comfort measures, emotional support, instruction and information and advocacy; or "other" which was defined as direct physical care related to assessment or procedures, indirect care in preparation of the room, etc., and all other activities (p.266). The results of the work-sampling were similar to those of Gagnon and Waghorn (1996) and NcNiven, et al. (1991) in that nurses were found to spend only 12.4 % of their time in supportive care. What this may not account for is the fact that sensitive and appropriate carrying out of assessment and procedures directly related to the woman's body may also be done supportively. Gale, et al. (2001) also included a semi-structured interview component to their study during which they asked nurses to discuss their perceptions of supportive care and the factors that influence it. Nurses identified coaching, physical comfort measures, emotional support, advocacy, and obtaining epidural analgesia for their patients as the key components of supportive care. The primary barrier identified in the provision of this care was inadequate nurse to patient ratio. Control by caregivers over the childbirth process was also seen as a barrier to support. This consisted in "the healthcare provider's use of technology, medical intervention, and rigid adherence to institutional policies and procedures" (p. 268). The authors note that although the nurses recognized these barriers, they did not choose to alter those that they could in order to provide greater direct support.

A similar work-sampling study conducted in Washington State, in which supportive care measures were comparably defined to those in Canadian studies, found that nurses spent 31.5% of their time in providing direct support to labouring women. However, little of this was actual physical support as only two of the seventy-five patients observed in care were not on continuous fetal monitoring. As results showed that the time spent in supportive activity decreased with an increase in patient load, it may be that this United States hospital was better staffed, or had a lower volume of deliveries, than those in the Canadian studies.

Another Canadian study also showed an inability or reluctance on the part of nurses to provide direct support to labouring women. Graham, Logan, Davies, and Nimrod (2004) used a qualitative case study method to examine the implementation of new intermittent auscultation guidelines introduced by the Society of Obstetricians and Gynecologists of Canada (SOGC). These guidelines discourage the use of continuous electronic fetal monitoring, proposing intermittent auscultation of the fetal heart during labour instead, and encourage the provision of continuous professional support during labour. Nurse managers and educators within all three hospitals championed this intervention and nursing staff was provided with education on the techniques of intermittent auscultation. The results showed a decrease in fetal monitoring by nurses across the three hospitals; however, direct labour support was increased in only one. This result is surprising as auscultation requires direct physical contact with women regardless of their activity or stage of labour. The authors report that reasons for this lack of labour support provision were attributed by the nurses to non-adoption of the SOGC guidelines as hospital policy, lack of medical acceptance and support for the change, fear of medico-

legal repercussions, reluctance to give up accustomed ways of working, and lack of knowledge and education in techniques for providing labour support. It is difficult to know what role individual hospital labour and delivery unit culture, leadership, staffing, architecture and technological accoutrements play in nurses' support to women. However, it is likely that these factors are significant.

It is evident from the studies reviewed above that the power and control by caregivers, whether intentional or simply customarily taken-for-granted, affects the relationships between nurses and childbearing women as well as the women's experiences of childbirth. Giarratano (2003) and Huntington (2002) explored nurses' relation with pregnant and childbearing women from a woman-centred perspective. Huntington (2002) found through qualitative feminist research that nurses providing care to women going through mid-trimester abortion offered these women non-judgmental, women-centred care; however, the nurses, as women themselves, were not well supported by institutional structures, nor given opportunities for collegial support in the emotional work of this caring. Using a phenomenological approach, Giarratano (2003) interviewed labour and delivery nurses who had participated in a baccalaureate nursing course introducing them to care based in a woman-centred philosophy about their practices. The participants in this study stated that incorporation of a woman-centred approach, consciously tailoring nursing practices to the individual woman, respecting women's choices, and when needed, advocating for these choices with medical practitioners, had improved their care of childbearing women and women's satisfaction with that care; however, it also sensitized the nurses to the ways in which the institutional practices of obstetrics in the workplace inhibited their attempts and put them at odds with other staff.

In both studies, offering woman-centred, relational care caused the participants to feel like 'outsiders' and/or unsupported by the milieu in which they practiced in their attempt to attend to the needs and desires of the individual woman.

All of the studies reviewed provide a portrait of hospital-based perinatal nursing that gives only general insight based in the social, institutional and technological factors that shape it. None of these studies provides a deep exploration of nurses' individual lived experience of caring for childbearing women. The only study located that addresses the perinatal nursing relation from this perspective was a feminist phenomenological study by Goldberg (2004). In this positive exploration of nurses' relationships with women, Goldberg (2004) illuminates the themes of 'engagement,' 'embodied trust,' 'woman-centered birthing' and 'power.' Her description shows the ways in which, within the constraints of the hospital context and biomedical epistemologies that view women as disembodied and disempowered in the act of childbearing, perinatal nurses work, often with subtle subversion of the system, to enable the woman to take hold of her body's ability to birth, understand the experience as her own, and find personal power within the birth experience. Like Goldberg's (2004) study, Chapter Four of this study also contributes to knowledge of perinatal nurses' lived experiences of caring for child-bearing women.

Women's Perceptions of Perinatal Nursing Care

Another view of the nature of perinatal nursing care of childbearing women can be gained through the perceptions, experiences, and reports of women themselves. The experience of childbirth in a woman's life has a radical and transformative effect (Bergum, 1989). Do nurses, midwives, and physicians realize the privileged and

psychologically crucial role they may play in this experience? Simkin (1991) explored the long-term impact of the childbirth experience in the lives of 20 women whose memories of their first births were recorded fifteen to twenty years after the fact. She found that nurses were vividly remembered, mostly in the context of satisfying birth experiences. Respect, continual presence, focused interest and support, and comforting touch were aspects of nursing care remembered positively. Negative memories included nurses' inability to the recognize, acknowledge, and support women's successful coping, and intrusive behaviours against which women felt they needed to defend themselves.

A qualitative study conducted by Mackey (1995) described women's self-evaluated performance during childbirth. This study suggests that the most important element in women's positive evaluation of their childbirth experiences was their own performance. However, women's awareness of events and the amount of information nurses gave them, as well as the support that nurses offered were also important contributing factors to a positive evaluation. Nurses were praised for keeping the women informed of progress and events, encouraging and helping them with coping techniques, and for the positive reinforcement that they offered. These results suggest that when nurses provide adequate information and offer women care respectfully and in collaboration with them, they are more likely to have positive childbirth experiences.

Callister (1993) interviewed 26 primiparous women, all of whom had epidural anaesthesia during labour, regarding the nurse's role in their childbirth experience. Women expressed high levels of satisfaction with the nursing care they received and identified support behaviours in three domains: emotional , informational, and tangible. Emotional support included being present, offering encouragement and reassurance, and

'coaching' the husband or coach. Informational support was provided by being truthful, providing instructions, explanations, and advice. Tangible support was in the form of physical comfort measures, and approaching women with gentleness and calm.

The results of a Canadian study by Bryanton, Fraser-Davey, and Sullivan (1994) were remarkably similar. This research used a Likert scale questionnaire to explore women's perceptions of nursing support in labour. Twenty-five supportive nursing behaviours were identified falling into the same three domains used by Callister (1993). The most helpful behaviours were "making the woman feel cared about as an individual, giving praise, appearing calm and confident, assisting with breathing and relaxing, treating the woman with respect, explaining hospital routines, answering questions truthfully in an understandable language, giving instruction in breathing and relaxing, providing a sense of security, and accepting what the woman said ...without judging her" (p.641). Most of these behaviours were in the domain of emotional support.

A more recent study by Mathews and Callister (2004) echoes the findings by Bryanton, et al. (1994) a decade before, as well as what was shown in Goldberg's study. These authors found that the ways in which care was given by perinatal nurses during labour and childbirth allowed women to feel valued and respected, supported their dignity and choice, and assisted women to maintain their preferred level of control. Support and encouragement, empathy, awareness of patients' sense of modesty, and good communication were key factors in women's satisfaction with their childbirth experience.

Providing information and education appear in all of these studies as important aspects of nursing care to childbearing women. Evans and Jeffrey (1995) conducted a longitudinal survey in two Canadian cities to determine if women's learning needs are

met during labour by nurses. Respondents indicated that women's needs and requests should guide teaching and that teaching during labour was desired as long as it was related to the immediate situation. Specific topics desired included coping, how to work with labour, pain control options, caesarean section, the progress of labour, monitoring, baby care in the delivery room, and procedures. Most of these learning needs were met satisfactorily with the exception of progress during labour, pain control options, and mother and infant care at delivery. Women observed that continuity of caregiver and adequate caregiver time at the bedside enhanced their learning. The authors conclude that women's learning needs should be assessed routinely during care in labour, and that institutional structures and staffing patterns need to reflect the important role nurses play as educators of childbearing women.

All of the research reviewed here provides insight into the nature of perinatal nursing and the relationships between women and the nurses who care for them. In the eyes of women nurses clearly have a significant role to play in providing support and education. The evidence to suggest that nurses do this to the degree desired or needed is somewhat equivocal. There is evidence that perinatal nursing is affected by the medical context in which it occurs and that nurses must attend to the expectations of other professionals, institutional protocols, and to the technology related to medical management of childbirth, as well as to the women whom they serve. Out of all of these studies, however, only Goldberg (2004) describes the lived experience of caring for childbearing women, and the relational aspects of this care, from the perspective of the nurse. Likewise, though the studies by Bergstrom, et al. (1992, 1997) provide some insight into interprofessional practice, nurses' experiences of interaction and shared care

with community-based midwives are absent from the literature. These areas are address in this study in Chapters Five and Six.

Midwives' Care of Childbearing Women

Theoretical and Philosophical Bases of Midwifery

Midwifery takes various forms internationally. For example, in the United Kingdom and the United States, midwives may be either direct-entry, that is not required to be credentialed in nursing or another healthcare profession, or they may be nurse-midwives who have extended their nursing education in order to become certified as registered midwives as well as registered nurses. In Canada, to date, provinces have adopted a direct-entry midwifery model. Regardless of whether or not midwives have a background in nursing, the philosophy of midwifery has its own unique focus on woman-centred care and the normalcy of childbirth, which is largely consistent globally. The scope of midwifery practice encompasses the same areas as perinatal nursing but is also broader. Midwives in British Columbia are primary perinatal caregivers, which means that they see women throughout their pregnancies and up to six weeks postpartum. In addition, midwives are independent practitioners. Though they may have hospital privileges, in Canada they are not hospital or government employees as nurses are.

Midwifery texts, like those for perinatal nursing, describe women-centred and family-centred care as central to the tenets of midwifery. An important aspect of this women-centred philosophy is mutual trust between the midwife and her client (Berg, 2005; Thorstensen, 2000), as well as mutuality, dialogue, and a shared sense of responsibility (Berg, 2005). Childbirth is seen as a "social event as opposed to a medical

one" and therefore the midwife strives to maintain it in the normal family context, even when there are deviations from physiologic norms (Bennett & Brown, 1999, p.4). However, there is a noticeable emphasis on woman-centred care as cardinal (Bennett & Brown, 1999; Davis, 1997; Varney, 1997). The midwife and woman work in partnership with the primary locus of decision-making in the woman (Bennett & Brown, 1999; Davis, 1997). Care is personalized through thorough assessment focused on the woman's experience and continuity of carer (Bennett & Brown, 1999; Davis, 1997). Childbirth is not seen as something to be managed but rather as a natural process that is facilitated without intervention except when indicated (Varney, 1997). Davis (1997) states that the essence of midwifery care is "staying in the moment, being humble, and paying attention...the antithesis of control" (p.5).

There are three core concepts that have been identified as comprising the Canadian midwifery model. They are informed choice, choice of birth setting, and continuity of care (Shroff, 1997; College of Midwives of British Columbia, 1997a). An additional and important manifestation of these concepts in practice is that, apart from time-limited, hospital-based midwifery demonstration projects that have taken place in the provinces of Alberta, British Columbia, and Ontario, Canadian midwifery is community-based; that is midwifery care and interaction with women is conducted in free-standing clinics and homes. Informed choice is premised on the belief that the childbearing experience belongs to the woman and her family, and reflects aspects of the ethnocultural, physiological, spiritual, intellectual and emotional attributes unique to her. She makes choices relevant to her own context based on comprehensive information provided by the midwife (Bortin, Alzugaray, Dowd & Kalman, 1994). Choice of birth

setting follows logically from informed choice and the tenets of woman- and family-centred care. It also reflects the importance of the option of homebirth for clients of midwifery care in Canada. Homebirth supports the view that birth is a normal and natural process accomplished by the woman and allows reliance on technological intervention to be kept to a minimum (Bortin, et al., 1994; Shroff, 1997). 'Normal' may be a much more individually defined parameter in midwifery than its specification by theory and measures used in the medical context permit (Davis-Floyd & Davis, 1997; O'Connor, 1993; Rooks, 1999). Continuity of care means that a woman will have midwifery care available to her throughout pregnancy, labour, and birth, and for up to six weeks post partum on a twenty-four-hour, on-call basis. She is cared for by the particular midwife of her choice primarily; and care is provided by not more than four midwives (e.g., in group practice), all of whom will be known to the woman (College of Midwives of British Columbia, 1997; Shroff, 1997). Continuity of care allows the woman to share her 'story' with the midwife making clear the meaning of events and priorities in her childbearing experience and freeing her from unsettling, brief encounters with new caregivers who are unknown to her as often happens in standard obstetric care. This continuity also provides the midwife with time for consistent, ongoing, and individually tailored assessment, education, and counselling (Rooks, 1999; Shroff, 1997).

The Nature of Midwifery

The nature of midwifery has been better studied from the perspective of midwives' experiences than perinatal nursing has from the experiential point of view of nurses. A review of some of these studies gives insight into aspects of the care of childbearing women by midwives. Two Ricoeurian phenomenological studies from

Sweden examine the experiences of midwives providing antenatal care to expectant women and couples (Hildingsson & Haggstrom, 1999; Olsson, Sandman & Jansson, 1996). Olsson, et al. (1996) analysed video-taped 'booking' (initial) interviews with pregnant women in their first trimester of pregnancy in five midwifery clinics. The authors found that the content of interactions with women represented biomedical, obstetric, social, antenatal, emotional, and life-style themes, which they reduce to two perspectives: obstetric and parental (focused on the process of becoming parents). The midwives ways of relating to women and their partners either showed consideration for the uniqueness of the expectant parents or disregarded this uniqueness. These two ways of relating occurred in all interviews but varied in proportion. Showing consideration for the uniqueness of couples was demonstrated by emotional involvement; striving to make a common connection; showing confidence in the couple's experiences, knowledge, and abilities; being open to their views and choices; and showing a willingness to support them. Disregard for the couple's uniqueness was evident in a lack of emotional involvement; disregard for the experiences, knowledge and abilities; uncertainty about offering support; and attempting to exert control. Expectant women also showed a variety of ways of relating. Some were open, honest, and confiding, while others were passive or indifferent, or even resistant and distanced. The relating style of the woman seemed to affect the degree to which the midwife showed recognition of her uniqueness. The men present were much less involved in the interactions though tried somewhat unsuccessfully on occasion to gain the midwife's focused attention. Generally the midwives controlled the interviews with the women adapting and submitting to the midwife's style and the content she initiated. The authors related the results of the study

to Buber's statements about the value of relationship in which the individual is affirmed and which is entered into as a partnership, person-to-person, rather than through objectification. They submit that this describes the two ways in which the midwives related to their clients; that is, both in partnership and, at times, with objectification. This study suggests that midwives are not always successful in being relationally ethical, at acting collaboratively with women, or at including the input of family members in interactions.

Hildingsson and Haggstrom (1999) used the same phenomenological method to analyze audio-taped interviews with seven midwives regarding their experiences of being supportive to women and couples during pregnancy. The results of this study were also found to have ethical implications. The midwives described providing support as "caring actions" based on (1) ethical intent, such as acting for the woman's good, being socially responsible, advocating on behalf of the baby or couple, and fostering the woman's autonomy; and (2) situational insight, "something between the words" or "emotions or vibrations from the woman" (p.85). They also described caring actions as increased professional involvement on behalf of women with high needs, or as "personal involvement" that was described as a feeling of togetherness, or friendship (p.86). 'Support' related to prospective fathers was not always supportive to them. Midwives spoke of educating them to support their wives, or excluding them for the sake of the woman. The authors state that men were sometimes invisible within the midwives' narratives. The midwives felt that fostering women's growth and development and facilitating their sense of security made their job satisfying. The authors' comprehensive interpretation of the midwives' care evoked a metaphor for them, "the good mother"

(p.82, 89). Though the care described here is clearly woman-centred, is it also exclusionary of men? There are aspects of the description that seem to portray a beneficence that borders on paternalism.

Two other authors, Fleming (1998) and James (1997), provide insight regarding the nature of midwifery through a focus on the relationship between midwives and the women whom they serve. James (1997) in particular shows through a phenomenological approach the nature of the midwifery relation. She speaks about the tenuous boundaries between a professional relationship and a friendship with some midwifery clients. She suggests that the boundaries within the midwifery relation are negotiated between the specific individuals involved. This allows not only for truly personalized care to take place, forged out of a deep knowing of the woman, but also for a stronger sense of moral responsibility to develop. She too uses the metaphor of the midwife as mother, among others, to characterize the hands-on, loving, caring work of midwifery that fosters and strengthens the woman's experience of childbirth and of herself.

Fleming (1998) conducted a qualitative study exploring the partnership between midwives and women clients in New Zealand. She found that the concept of partnership with women was extremely important to midwives who described themselves as facilitators, affirming the woman, asking what her expectations are, and allowing her to make her own choices. Midwives valued women's feelings and intuitions; however, they realized that there are times when women need to rely on the midwife for directive guidance. Though all the women Fleming interviewed expressed satisfaction with their midwifery care, there were incongruities and contradictions in some midwives' and clients' perceptions of events during labour. Also, statements like, "I won't need her for

support!...She'll be there just to do the medical side of it" (p.10) speak of a detached view of relationship unlikely to foster a sense of partnership. Fleming attributes some of the differences between the views of women and their midwives to the dominance in women's thinking and assumptions of the medical model of care, which assumes a hierarchical relationship between caregiver and client. This was contrary to the midwives' understandings and expectations of the care they offered.

A qualitative study conducted by Kennedy (2002) in the United States revealed a constitutive theme of the midwife as the "'instrument' of care" (p. 1760) in an environment with increasing reliance on technology in childbirth. The midwife participants in this study described their practice with childbearing women as providing a "vigilant stance in regard to assessment and guardianship of the birth process", seeing as paramount the "optimal health of the mother and infant", creating an environment that was "safe and inspired a sense of normalcy", and offering respectful care in partnership with the woman and her family (p. 1759-1760). Similarly, in a study of midwives caring for high risk women, Berg (2005) found that midwives considered maintaining a balance between natural and medical perspectives was essential in the care they gave as was protecting the dignity of their clients in the face of increased medical surveillance. Hunter (2004) records midwives feelings of stress when medical understandings of birth and the importance of women's informed choice in their care are violated by the effects of other care providers attitudes and institutional demands that shape midwifery mediated births in the hospital setting.

Women's Perceptions of Midwifery Care

Just as in the case of perinatal nursing, women's experiences of childbirth under the care of midwives can provide insights into the nature of midwifery care. An older study, but one that is frequently cited, conducted by Green, Coupland, and Kitzinger (1990) used questionnaires, two at different times during the third trimester of pregnancy and one at six weeks postpartum, to explore women's expectations and experiences of childbirth in the United Kingdom. A sample of 710 women completed all three questionnaires. The outcome variables examined were fulfilment, satisfaction, emotional well-being, and words used to describe the baby. Information and feeling in control appeared as major themes in the results and "were consistently associated with positive psychological outcomes" (p.15). Women who felt they received adequate information from caregivers prenatally were happier postnatally; and those who received the right amount of information postnatally scored highest on all four outcome measures. Women who felt they had no control over themselves or their environments were least satisfied and fulfilled, and had low postnatal well-being. Feeling in control was related most to "feeling in control of what staff did to them" and to "the sort of relationship that they felt they had with the staff" (p.22). Staff here includes midwives and physicians. In addition, the freedom to get into comfortable bodily positions was strongly related to feelings of control over what staff did, and to all four of the outcome variables. This study speaks to the importance of the midwife's role as an educator and as a caregiver who is knowledgeable of the individual woman, sensitive to and respectful of her desires and needs throughout the childbearing process, and of the tremendous impact this care can have on women's lives.

Three qualitative studies (Fraser, 1999; Halldorsdottir & Karlsdottir, 1996; Kennedy, 1995) that explored women's perceptions of midwifery care found similar aspects were important to the women interviewed. Women appreciated midwives who established a special, caring relationship with them that was affirming, supportive, and formed the basis for individualized care. They expected to be given adequate time with their caregivers to foster this relationship and continuity of carer was highly valued (Fraser, 1999; Halldorsdottir & Karlsdottir, 1996; Kennedy, 1995). They appreciated respectful and trusting relationships and saw the midwife as someone who would advocate for them when necessary (Fraser, 1999; Kennedy, 1995). They wanted to be given information and to be free to exert their autonomy in making choices based on available options (Fraser, 1999; Halldorsdottir & Karlsdottir, 1996; Kennedy, 1995). They felt it was important that their caregivers were clinically competent (Fraser, 1999) and could assist them in maintaining control over their labour and birth experience (Fraser, 1999; Halldorsdottir & Karlsdottir, 1996; Kennedy, 1995). The women in Fraser's (1999) study also mentioned the importance of gender, that is, of having women as caregivers; and unlike some of the women in Fleming's (1998) study (above), saw the midwife's role as different from the physician's. The women in Fraser's (1999) study also felt that midwives should strive for collegial, collaborative relations with other healthcare providers.

Though some of the studies reviewed here use phenomenological methods to elucidate midwives' lived experience of caring for childbearing women, with the exception of James's (1997) study none examines midwifery from a Canadian perspective using this methodology. In addition, James's (1997) research specifically

examined the nature of the midwifery relation. Though this included the experience of caring for childbearing women, it did not explore the experience of caring for women in collaboration with nurses in the hospital setting. My study proposes to fill this gap.

Interactions Between Hospital-Based Nurses and Community-Based Midwives

Interprofessional Conflict

Many in the medical and nursing communities contend that to be a midwife one must first be a nurse, that midwifery is a facet of perinatal nursing. The practice of autonomous community-based midwifery angers, confuses, and worries them (Bourgeault & Fynes, 1996-7; Kornelsen, 2000; Kornelsen, et al., 2000; Lyons & Carty, 1999; McKendry, 1996-7). Maternal-child nursing and midwifery share skill sets and large areas of knowledge in common, and are both almost exclusively practiced by women. However, the ways in which they have been shaped as professions, and the material contexts for practice, seem to contribute to factors that play into occasions of misunderstanding and antipathy between these groups of practitioners. Various authors suggest that these factors may stem from philosophical differences regarding the nature of childbirth (McKendry, 1996-7; O'Connor, 1993; Rooks, 1999), from nursing's identification as a facet of mainstream medical obstetrics (Kornelsen. 2000; Kornelsen, Dahinten & Carty, 2000; McKendry, 1996-7), and from community-based midwifery's identification as an alternative (Rooks, 1999). Together these have created an attitude among nurses (and physicians) that devalues midwifery skill and knowledge acquired outside of institutional settings, and a corresponding view of nursing among many midwives as an extension of, and support to what is considered the paternalistic,

interventionist model associated with obstetrical medicine (Kornelsen, 2000; Kornelsen, et al., 2000). It is possible that nursing's medically tailored, and both subordinate (to medicine) (Boutilier, 1994; McPherson, 1996; Stuart, 1994) and somewhat elitist (among women) (Boutilier, 1994) beginnings, as well as midwifery's informal, grassroots (Burtch, 1994; Relyea, 1992), and more recently feminist (Sharpe, 1997) origins in Canada have contributed to these views. Conflict over professional territory between nursing and midwifery is not new (Burtch, 1994; McPherson, 1996; Relyea, 1992), and exclusionary acts have been committed by both groups.

Midwifery Regulation and Integration

The regulation of midwifery in Ontario provides examples of exclusion on the part of both nursing and midwifery. Bourgeault and Fynes (1996-7) document how in 1984 when midwives in Ontario sought integration into the provincial health care system, the Ontario Association of Midwives, made up of community-based midwives, and the Ontario Nurse Midwives Association decided to merge and to submit a joint proposal to the Health Professions Legislation Review. It was anticipated that this united front would consolidate consumer support, give credibility to community-based midwifery in the eyes of the medical establishment, and lend support to the viability of a more independent model of practice than the medically supervised nurse-midwifery model. This joint proposal sought to include multiple routes of entry into the profession, i.e., either through direct entry or through nursing. The response of nursing professional organizations to this proposal for recognition of midwifery as a separate health care profession was perhaps predictable. The College of Nurses of Ontario claimed that midwifery did not represent a distinct profession apart from nursing. Likewise, the Ontario Nurses Association stated

that they could not support the integration of lay midwives. Both organizations recommended that midwifery practice be regulated under the jurisdiction of nursing. Nevertheless, midwifery became recognized as a health profession by the Ontario government in January of 1986 (Bourgeault & Fynes, 1996-7) and regulated through the Midwifery Act in 1991 (Canadian Legal Information Institute, 2006). An initial process in the integration of midwifery was the assessment and 'grandmothering' in of experienced practitioners while a baccalaureate educational program in midwifery was developed. One hundred and twenty applications were received for this assessment process. Of these, forty-eight applicants were rejected because they lacked midwifery experience in Ontario, or because they lacked home birth experience. In effect this process excluded immigrant nurse-midwives and maternal-child nurses (Bourgeault & Fynes, 1996-7; Nestel, 1996-7). In addition, the choice for and development of a four-year baccalaureate program in midwifery, with no process for granting credit on the basis of prior education or experience, excluded nurses and nurse-midwives unless they were willing to return to school and complete a four-year program, but assured the inclusion of direct-entry midwives. Thus, the initial plan for multiple routes of entry into the profession was narrowed to exclude nurses and include only experienced community-based midwives or those entering through the direct-entry educational route (Bourgeault & Fynes, 1996-7).

McKendry (1996-7) reports that midwives' contemporary efforts to carve out a recognized, autonomous, professional niche in Alberta have been largely unsupported by nurses, with the exception of a small but active group of nurse-midwives at the University of Alberta. In the early 1990s, when Alberta's midwives sought formal

professional status, both physicians and the Alberta Association of Registered Nurses (AARN) were opposed to recognition of 'lay-trained', community-based midwifery, though the AARN did recognize and support nurse-midwifery (Alberta Association of Registered Nurses, 1991; McKendry, 1996-7). McKendry (1996-7) argues that Alberta's nurses sought dual closure strategies when it was evident that midwifery would gain recognition and regulation under the Health Professions Act. One strategy was to attempt to incorporate midwifery as a sub-discipline of nursing through a nurse-midwifery educational program; and another, based on economic factors and need, implied that midwives' skills and services were redundant and untrustworthy. The reasons for this response, according to McKendry (1996-7) were philosophical and political. Nurses believed that the midwifery view of childbirth is naïve and unsafe. They also saw that midwives were being granted an autonomy that nurses themselves struggle for, but partly because of their position in healthcare and medical hierarchy structures, are not granted.

The Registered Nurses Association of British Columbia (RNABC) had a similar response to that of the AARN when midwives began lobbying for registration in British Columbia. The RNABC initially only supported the practice of nurse-midwifery. However, a position statement published in 1997 states the RNABC's recognition of midwifery as an autonomous and regulated health profession, but suggests that perinatal nurses' role be expanded to include similar autonomy in assisting low-risk women to birth (Rice, 1997; RNABC, 1997). Midwives became registered and publicly funded in British Columbia in 1998.

Kornelsen, et al. (2000) conducted a survey of British Columbia hospital-based perinatal, and community health, nurses to examine their knowledge of midwifery

registration requirements, perceptions of community-based midwifery, and to explore their concerns regarding midwifery integration into the health care system. A paper and pencil questionnaire was sent to a stratified random sample generated from RNABC lists. A total of 223 useable questionnaires were returned, 129 from hospital-based nurses and 94 from community health nurses. Hospital-based nurses were more knowledgeable than community health nurses about midwifery registration, model, and scope of practice. Community health nurses had more favourable perceptions of midwifery generally than hospital-based nurses. Both groups of nurses were more favourable toward hospital-birth under midwifery care than homebirth. Though they agreed that midwifery care offered greater choice and continuity of care for women, and did not believe that women would have reduced quality of care, 65.6% of the hospital-based nurses, and 39.8% of the community health nurses, felt that homebirth posed an increased risk to the mother, and 68.8% of hospital-based nurses and 41.9% of community health nurses felt the baby would be at increased risk. Surprisingly as many as 21.3% of hospital-based nurses believed that the baby would be at increased risk under midwifery care even in the situation of hospital-birth. Hospital-based nurses believed that midwifery integration would have negative impacts on nursing practice. Over 40% believed that there would be decreased employment and job loss for nurses, less allocation of funds to nursing, and loss of professional autonomy. Over half (57%) believed that there would be conflict between nurses and midwives, and 79.1% felt that there would be confusion regarding lines of authority and communication. Qualitative responses to the questionnaire revealed that of those nurses who had interacted with midwives, 33% of their experiences were negative and 19% positive. Most positive experiences were with foreign trained nurse-

midwives working as perinatal nurses while negative experiences were predominantly with community-based midwives.

As in Ontario, many perinatal nurses in British Columbia feel excluded from the midwifery registration process and believe that their considerable knowledge and experience are not recognized for political reasons (Kornelsen, 2000). In a separate report, Kornelsen (2000) outlines what perinatal nurses view as the major obstacles to their ability to register as midwives. They are: a philosophical rejection of homebirth as a "viable option", and perceived discrimination against them because of this; objection to "being part of a group that condones 'working beyond the law'" (midwives practiced illegally before registration); "lack of a training facility in B. C."; "geographic isolation"; and lack of professional support (p.25). Many nurses believe that preferential treatment is being given to practitioners with less training and experience. Kornelsen (2000) notes that this is "a recipe for hostility and professional jealousy and breakdown of interprofessional relationships" (p.25).

Quebec concluded a pilot project of midwifery care offered in free-standing birthing centres. Evaluation of this project also indicates tension and territorial confusion on the part of nurses and other healthcare providers in interacting with midwives in situations of shared maternity care when midwifery clients required transfer to the hospital for necessary medical intervention (Collin, Blais, White, Demers & Desbiens, 2000).

Issues of Client Comfort and Safety

The literature also reveals midwives' accounts of discomfort, frustration, and antagonism when accompanying their clients into the hospital setting (Creasy, 1997;

Davis-Floyd, 2002; James & Pauly, 1999; Sharpe, 1997). This is an ethical problem for the professionals involved. Caregiver uncertainty regarding role expectations, perceived threats to professional identity and domains of practice, are negative influences in situations that demand good communication and collegial working relationships. More importantly, these responses may well have detrimental effects on the comfort, well-being, and safety of women who find themselves requiring the mutual care of nurses and midwives under circumstances of choice or necessity. For example, James and Pauly (1999) describe a situation in which a woman, transferred into hospital accompanied by her midwife for the treatment of a postpartum hemorrhage, nearly bled to death due to what seeed to be punitive neglect on the part of hospital staff. Davis-Floyd (2002) also relates accounts of fetal death due to disrespect toward and mistrust of the midwife and her client on the part of hospital and emergency transport personnel.

To date, interprofessional relations between nurses and midwives have been examined historically, sociologically, politically, and ideologically as is evident in this literature review. However, the interaction of nurses and community-based midwives in the shared care of childbearing women has not been explored through their lived their experiences. This study makes a contribution to filling this gap in the research literature. It also extends and deepens the research that has been done by Kornelsen et al. (2000) regarding interprofessional relationships between nurses and midwives in British Columbia.

Interprofessional Collaboration

The interaction of nurses and midwives in the care of women within the hospital context can be enhanced by intentional collaboration and cooperation. Collaboration among healthcare providers as a construct has been variously defined; however some sub-concepts are consistent across definitions: clinical competence, cooperation, mutual respect and trust, communication, shared decision-making, and mutual support (Herbert, 2005; Keleher, 1998; Schober & McKay, 2004; Stapleton, 1998). Individual authors add other sub-concepts such as, accountability, assertiveness (Keleher, 1998; Schober & McKay, 2004), risk-taking (Keleher, 1998), autonomy (Hall, 2005; Schrober & McKay, 2004), coordination, and common care goals (Schrober & McKay, 2004). D'Amour, Ferrada-Videla, San Martin Rodriguez and Beaulieu (2005) and Herbert (2005) add that participation of the patient is also a criterion. The implication in these definitions is that of mutual endeavour and mutual support in the accomplishment of patient/client care. D'Amour, et al. (2005), in a literature review of core concepts and frameworks related to health care provider collaboration, highlight sharing of responsibility, decision-making, values, planning and intervention; partnership in collegial, open, honest relationships; interdependency; and a dynamic, evolving, interpersonal process (p. 118-119).

Some of the participants in this study refer to relation and collaboration with other caregivers and patients/clients as the experience of being part of a 'team.' This sense of belonging and mutuality stands out for them as either present or absent in shared care situations. 'Collaboration' is closely associated with the concepts of 'team' and 'teamwork' (D'Amour, et al., 2005; McCallin, 2001). Teams interact in collaboration, and teamwork is the goal-oriented work of collaboration (McCallin, 2001). Four types of teams have been identified in the literature. The intradisciplinary team is made up of

members within the same health discipline (Schober & McKay, 2004). The multidisciplinary or multiprofessional healthcare team is comprised of health professionals from different disciplines who may consult with one another in planning, but are otherwise juxtaposed and independent in carrying out their disciplinary competencies (D'Amour, et al., 2005; Schober & McKay, 2004). The interdisciplinary or interprofessional healthcare team is also made of up members from different disciplines who work to integrate and translate their various competencies with a strong sense of team identity (D'Amour, et al., 2005; Schober & McKay, 2004). D'Amour et al. (2005) describe the interdisciplinary team as "a structured entity with a common goal and a common decision-making process" and suggest that it is "based on an integration of the knowledge and expertise of each professional" in order to address complex issues in a "flexible and open-minded way" (p. 120). The fourth type of collaborative healthcare team is the transdisciplinary team. The transdisciplinary team engages in practice and learning across disciplinary boundaries through the deliberate exchange of knowledge and skills and in this way members work in expanded roles. In addition, the transdisciplinary team seeks consensus in decision-making for common goals (D'Amour, et al., 2005; Schober & McKay, 2004).

Approaches and Strategies for Collaborative Practice

Many of the successful strategies for collaboration have been outlined in the criteria for the construct. DeMarco, Horowitz and McLeod (2000) advocate for the use of nursing values in making collaboration succeed. Specifically they suggest reciprocal caring among members of the team, mutual reflection, and social support. Schober and McKay (2004) emphasize that clear communication, participatory inclusion, shared

power and leadership, and consensus are also means to successful collaboration. In addition, clarifying roles, goals, and ensuring that environmental factors and resources are in place assist in successful team efforts. Harkness, et al. (2003) echo these points and suggest the importance of tact and diplomacy in interactions. Stapleton (1998) identifies the necessity of seeking to understand and value team members' disciplinary worldviews, styles and scopes of practice.

Barriers to Collaboration

Barriers to collaboration are primarily interpersonal. They reside in professional competitiveness, poor communication (Keleher, 1998; Schober & McKay, 2004) stereotyping (Mandy & Mandy, 2004), and exclusionary behaviours (Hollenberg, 2005). Professional cultures and education have historically created 'silos' of expertise and practice with little cross-fertilization. This isolation and elitism, along with prejudice based in gender and social status, have contributed to professional envy and hierarchical attitudes (Hall, 2005; Schober & McKay, 2004; Skjorshammer, 2001; Stapleton, 1998), which, in turn, can lead to conflict and avoidance (Skjorshammer, 2001). Overcoming these barriers requires a conscious desire and personal effort that cannot be mandated. The practice of collaboration begins with individuals in the one-to-one relationship (Stapleton, 1998).

Benefits of Interprofessional Collaboration

The benefits of interprofessional collaboration are many. Those identified in the literature include: increased satisfaction in the healthcare encounter for both the provider and the patient, more efficient use of services and time, decreased length of hospitalization, cost benefits, improved continuity of care, and improved working

relationships that allow for synergy in solution generation, decreased conflict, and better coordination (Keleher, 1998; Schober & McKay, 2004). Harkness, Smith, Waxman, and Hix (2003) explored their own and one another's experiences of collaborative healthcare practice. They found that they were enhanced both personally and professionally through improved clinical expertise, being deepened emotionally and spiritually, learning through referral and consultation with other healthcare providers, and increased self-awareness and personal fulfillment.

The benefits for collaborative perinatal care have been recognized in Canada and pilot projects are underway involving midwives, nurses and physicians in a multi-ethnic urban setting and a rural/remote northern setting. The evaluation of these projects has not been completed; however, preliminary outcomes show promising improvements in perinatal health for the populations served. Equally important is the learning and growth that the members of these interprofessional teams are experiencing (Multidisciplinary Collaborative Primary Maternity Care Project, 2005). The research presented here also points to the benefits of collaborative perinatal care in the acute care setting, in part by showing caregivers' experiences when collaboration and collegiality are lacking.

Summary

This literature review has investigated the importance of ethical relational between caregivers and patients/clients, and the nature and relational aspects of perinatal nursing and midwifery. In addition, the literature on interprofessional collaborative practice has been reviewed for the insight it will give to the discussion of interactions between nurses and midwives to follow in this study. Perinatal nursing has been

described both qualitatively and quantitatively but has been little explored specifically from the perspective of nurses' lived experience of caring and relating with childbearing women. The midwifery relation and experience of practice have been better researched from this perspective. However, the interaction of perinatal nurses and community-based midwives has not been studied from the perspective of caregivers' lived experience. Such a study is particularly relevant in the Canadian context where midwifery is newly regulated. By exploring perinatal nurses' and midwives' experience of caring for women together in both its concreteness and its meaning this research offers insight regarding the shared and unique aspects of nursing and midwifery, contributing to understanding that will be helpful in fostering collegial, collaborative working relationships.

CHAPTER THREE

FINDING THE METHODOLOGICAL WAY

Exploring the Mystery of Relation

A qualitative methodology is most appropriate to the topic of this inquiry because the questions seek to understand the nature and meaning of lived experience. There are many qualitative methods that could serve as paths to this end; however, the questions explored by this study point to one method in particular that is most appropriate; hermeneutic phenomenology. As stated in Chapter One, the phenomenon to be explored is the experience of relation. In this study this is done through analysis of lived experience accounts of interaction between hospital-based nurses and community-based midwives with one another and with childbearing women.

Chapters One and Two have posed the problem of conflict and antipathy in the interprofessional relations between these two groups of caregivers. Problems need to be understood through description and analysis. This may begin with the lived experiences of individuals, although there are many other ways of obtaining data about them. However, eventually a degree of abstraction is needed that removes a problem from the realm of the particular and allows it to be viewed more generally and objectively in order to be solved. In this way problems can be addressed effectively through conceptualization and the development of theoretical models, valuable means of increasing formal knowledge and implementing change at a more generalized and structural level.

Relation is the grounding from which the interprofessional problems posed come. It is an existential, experiential phenomenon, as has been discussed, and as such is a

mystery not amenable to abstraction. In addition, the ethical dimensions of relation must inevitably remain rooted in the personal; found, lived, and altered at the individual level. The experience of relation involves our whole being in a way that objectively addressed problems do not. To be in relation is an emotional, rational, often physical, and sometimes spiritual experience. Its mystery is that to explore relation requires exploration and experience of self and other, subjective and intersubjective being. It is for this reason that to explore the phenomenon I employ a method that not only begins with lived experience, in this case the experience of relation between individuals, but seeks to remain in it, intensifying through analysis its power to elucidate the meaning of the phenomenon. Changes in relationships ultimately occur within individuals in response to evocation, a call to some different way of being or an opening onto an altered vista of self and other. This involves a shift in meaning and significance. Hermeneutic phenomenology provides a means of both evocatively showing phenomena and of bringing underlying meanings to awareness. This endows the method, if used with skill and integrity, with the potential to be "a critical philosophy of action", calling the reader of the phenomenological text to deepened thought that "radicalizes thinking and the acting that flows from it" (van Manen, 1997a, p. 154). It is in this regard that hermeneutic phenomenology can have a profoundly moral impact. In the context of this study it is hoped that its use will call the reader to more ethical relation.

Hermeneutic Phenomenology

Phenomenology is the systematic, explicit study of phenomena as experienced and apprehended through human consciousness. It uses descriptive, textual methods to show phenomena concretely, allowing them to reveal their own substance and

significance (van Manen, 1997a). Phenomenology provides a method suited to exploration and description of individual lived experience through the presentation of evocative, thickly (having depth and dimension) described personal anecdotes, which can be analyzed for their unique constitution, and even juxtaposed like the two anecdotes in Chapter One, to stir a sense of wonder, questioning and reflection. The adjective, hermeneutic, means interpretive, elucidating meaning. Phenomenology, regardless of the philosophical school followed, is always hermeneutic because textual description is an interpretive mode of expression. Hermeneutic phenomenology here refers more specifically to the phenomenological method according to van Manen (1997a) and informed by the philosophical writings of Heidegger (1962) and Gadamer (1997). An intentionally hermeneutic approach to phenomenology requires that, in the process of writing and analysis, phenomenological descriptions are plumbed for their underlying existential meanings, showing them as they give significance to every-day life (van Manen, 1997a). A premise of hermeneutic phenomenology is that lived experience itself is in many aspects pre-reflective and in this sense uncontemplated as regards the taken-for-granted givens that shape it, such as the structure of language, cultural, and societal and historical situatedness; in short, our unrealized 'prejudices' (Gadamer, 1977, 1997). Therefore, in exploring its meaning, experience must be brought to consciousness retrospectively and reflected upon (van Manen, 1997a).

Van Manen (1997a) suggests four existentials that provide a context for orienting to the phenomenon in this reflective process. They are: "*lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived human relation* (relationality or communality)" (p.101). The analysis of lived experience, then, occurs through an

ongoing and doubly interpretive process: first of all through the textual description of experience; and secondly, through the reflection on, questioning and exploration of the meanings that underpin both details and the entirety of the experience described. These interpretations work synergistically and the phenomenon is viewed through the relationship of part to whole in the manner of Gadamer's (1997) hermeneutic circle (p.190, 291).

The purpose of the rich phenomenological description and interpretation characteristic of this method is to engage the reader in a dialogic relation with the text and thus with the experiential phenomenon and its meaning. The reader is called to imagine the experience in a way that establishes the possibility of intersubjectivity between herself and the one to whom the anecdote belongs. In this sense the reader too is involved in an act of interpretation. This reflective process potentially evokes in the reader a deepened understanding resulting in a more perceptive, thoughtful, and tactful awareness of her own lived experience with others in the world (van Manen, 1997a).

The Possibility of Finding 'Truth' in Lived Experience

Empirical natural science that holds to the tenets of detached objectivity, control, replication, and quantification leans heavily on specific and narrowly defined methods as the criteria for knowledge generation and the warrants for truth. Within this epistemological system individual experience has little import unless it can be methodically shown to be repeatable in the same form with the same results to a statistically significant degree. Truth is premised on repetition, irrefutability, and meaningful generalization. In short, this positive empiricist approach is concerned with "clarifying the idealization that is endemic to science" (Gadamer, 1997, p. 259).

Phenomenology is empirical in the pure sense of the word, drawing on phenomena perceived through the senses and experienced by people as embodied beings; but, as has already been described, it is an 'interpretive' rather than an 'objective' science. Van Manen (1997a) describes phenomenology as human science concerned with the study of how persons experience the world, an examination of the essence of human 'being' in its myriad, unique revelations. In phenomenology then, lived individual experience is the endless source of understanding as it reveals the multifaceted nature of human life. As a phenomenologist explores and seeks to understand the experience of persons, she also comes to a deepened understanding of the life-world, and our objects of meaning, in which our being is embedded. The aim, therefore, of hermeneutic phenomenology is this understanding, not explanation or prediction. Gadamer (1997) describes understanding, or *verstehen* as it is expressed in German, as relevant to knowledge but more importantly as having the sense of "recognition, of being well versed in something" (p.260). What phenomenological examination of individual lived experience offers in the understanding of a given phenomenon is the reflective bringing to mind, in a deepened way, of our experiences of the world. Such understanding can be recognized as the uncovering of aspects of a larger, more complex whole, a larger 'truth.'

The relevance of 'truth' for phenomenology is not so much the Latin understanding of *veritas,* the defensibly factual, as it is the Greek understanding of *aletheia,* "the revealing of beings" (Heidegger, 1993, p. 184). Heidegger (1993) suggests that truth contains "the not-yet-revealed, the un-uncovered" as well as that which is shown (p. 185). And that which can be shown, the revealed "open region" understood as true, is historically circumscribed. It can only be glimpsed in a particular way because of

"being"; that is, contextualized, lived human experience, which gives us a particular focus and shapes the curiosity and questions that compel us to seek understanding, as well as the creative means and styles with which we choose to communicate it (p. 186-187). So for a phenomenologist seeking to illuminate being by bringing lived experience to an 'open region', "there is a 'truth' to be had, and understanding to be reached, in the unmethodical incidents of our lives" (Jardine, 1992, p.54-55). Seemingly prosaic, taken-for-granted aspects of human life are full of richness to be explored. The facets of truth offered by phenomenological inquiry bring a deepened awareness of phenomena along with reflection on, and questioning of, what is still to be revealed (van Manen, 1997a).

This study offers an 'open region' within which light is shed through the window of perinatal nurses' and midwives' experiences as a facet of the larger 'truth' of the phenomenon of relation. The intent is to present these participant accounts in a way that creates resonance with, challenges, and extends the insights that the reader may already have of this phenomenon from within his or her own experience, deepening understanding so that it becomes a lens through which future interactions can be refocused. Van Manen (1997a) suggests that phenomenology is a philosophical "theorizing of the unique" (p.154). This kind of understanding allows one to move beyond generalization, formulaic methods and rules to thoughtful action that is relevant to person and context.

Reflecting on Lived Experience: Applying the Hermeneutic Phenomenological Method

Van Manen (1997a) outlines six aspects of the process for conducting hermeneutic phenomenological research. They are as follows:

(1) turning to a phenomenon which seriously interests us and commits us to the world;

(2) investigating experience as we live it rather than as we conceptualize it;

(3) reflecting on the essential themes which characterize the phenomenon;

(4) describing the phenomenon through the art of writing and rewriting;

(5) maintaining a strong and oriented pedagogical relation to the phenomenon;

(6) balancing the research context by considering parts and whole (p. 30-31)

These steps and van Manen's explication of them provided a guide for this study. The first step, turning to a phenomenon that interests me, to which I am committed, and that is of significance for nursing, midwifery, and the relational ethics of interprofessional practice has been addressed in Chapters One and Two. The second step, investigating experience as it is lived, will be addressed here. These actions involved the recruitment of participants who were to be the source of lived experience descriptions, reflection on the contexts relevant to this study, meetings and conversations with the participants, my efforts to keep our dialogue open as we explored the phenomenon together, and the recording of their words. The other steps of the method are shown in the following chapters that contain analysis of and reflection on the participants' accounts.

Calling Midwives and Nurses

Clearly the phenomenon of interest to me for this study was also of interest to the participants and I was overwhelmed by the response of those who volunteered. In the end twenty-one women participated; eleven midwives and ten nurses. As the research questions indicate, the participants were hospital-based, registered, perinatal nurses (RNs) working in the area of obstetrics and maternal-child care, and community-based, registered midwives. I hoped for the inclusion of some nurses with a midwifery background and some midwives with a nursing background because I wondered if and how this cross-over in education and socialization might shape their experiences. All of the participants were 18 years of age or older, fluent in English, and recruited within the Province of British Columbia.

Community-based midwives were defined as those whose primary context for practice is in the community rather than the hospital. These midwives saw women in homes or free-standing clinics for prenatal and postpartum care, and generally facilitated childbirth in the setting of the client-woman's choice (College of Midwives of British Columbia, 1997). Some of the midwife volunteers have a nursing background. Midwives were recruited through the Midwifery Association of British Columbia (MABC) after I obtained support from the MABC Executive and permission to contact their membership personally via information provided on the Association website. All registered, practicing midwives in British Columbia were sent an information letter and invitation to participate, a phone number and email address at which I could be reached, and a reply card with a stamped, addressed envelop were included. In addition, an advertisement was

placed in the MABC newsletter including my contact information. The midwives who volunteered to participate in the study practiced in both urban and rural communities.

The registered perinatal nurse participants included individuals whose primary areas of practice were labour and delivery, antepartum/postpartum and neonatal care. As it happened, none of the nurses who volunteered had a midwifery background; that is, had worked as a midwife in another country but only as a perinatal RN in Canada. Nurses were recruited from four hospitals that provide services to childbearing women from both urban and rural communities in four different urban centres in the interior, lower mainland, and islands of British Columbia. After obtaining support from relevant nurse managers, perinatal nurses were contacted by means of information posters displayed in perinatal care areas attached to which were reply cards with stamped, addressed envelops.

Settings and Contexts of Relation

The lived experience accounts for this study were collected in a variety of settings chosen by the participants including homes, cafes, offices, clinics, in parks, on a boat, and in a dormitory room. Each woman's presence in the place where we spoke revealed something of her uniqueness. But the participants' anecdotes and reflections richly conjured other places and ambiances: labour and delivery rooms, small and large hospitals, urban and rural communities, living rooms, bedrooms, pools of water, music and dancing, travels over dark roads or water. In every setting they described, relation was woven into the human context as the warp of nursing and midwifery care. Because this inquiry seeks to illuminate the experience of relation between hospital-based nurses and community-based midwives, the anecdotes gathered about these particular experiences and presented here took place primarily in the hospital setting. Birth stories

and stories of participants' relationships with women and their families took place in the hospital and, particularly in the case of midwife participants, in homes and clinics.

Within the Hospital

Hospitals in British Columbia seem to define 'institutional' in their appearance, with uniform windows and fixtures and a techno-utilitarian aesthetic of metal, glass, concrete and stucco on the outside. Inside they are all hard surfaces in innocuous pastels and beiges. On entering a visitor or patient still feels a sense of being on the periphery, an outsider. The interior is designed as a mixture of carefully regulated surveillance and concealment, giving the outsider access only to the spaces to which they are assigned or allowed. The long shiny corridors, heavily doored or curtained rooms, and the barricaded nurses' stations can be enigmatic and foreboding to all but nurses, physicians, and uniformed hospital personnel. But much of what is not available to the eye of the visitor is detected by the nose and ears, conflating with anticipated images of pain and illness, loved ones in distress. Anonymous voices moaning or calling out, caregivers' reassuring, instructive or imperative tones assail one along with the squeak of rubber soles against the polished flooring or the rhythmic, muffled rattle of a passing gurney. Many smells are peculiar to each hospital unit, but overall is the hospital's singular odour, a vague bouquet of cleaning products, isopropyl alcohol, body fluids and latex. One whiff may cause spontaneous anxiety and a knot in the gut; overwhelming relief and submission of muscle and bone to the promise of skilled help and healing technology at hand; or an ambivalent mixture of these sensations. It is difficult not to become 'a patient,' not to surrender to the authority of the surroundings and those who move with confidence in them.

The hospital as a place – as a space within which relation occurs and grows – is its own distinct corner of the life-world. For those who work there, hospitals have a micro-societal quality; that is they are an intentional association of people for specific ends who interact and perform their work within a pragmatic and superimposed social structure. As Macmurry (1999, p.128) says of societies, although the members of such inorganically developed social entities may come together out of their original, individual heterogeneities, they become more homogeneous in the context of such a social space. This homogeneity distinctly differentiates those who work as health care providers primarily within the hospital from those who visit the hospital but are not a part of its society. A visitor often feels a childlike sense of trespassing into an unintelligible adult world in which only medical initiates move with comprehension.

Relationship between those who visit and those who belong is, at least, earned by virtue of the visitor's need and, at best, a genuine, spontaneous reflection and expression of human respect and good will. However, the quality of relation offered by a health care provider depends on the individual; regardless of the expectation that those who work in the hospital will be gracious based on both professional codes of ethics and the general 'governmental' structure and rules of the hospital as a public institution. Unfortunately, however, rules and codes of ethics can not hold enough external power over individuals to consistently commit them, in a personal way, to relationally ethical interaction (Bauman, 1993). The currents of homogeneity, of needing to identify as a part of not just the micro-society but its subgroups may be a stronger influence when it comes to interacting with those from the outside. There is also an institutional need to homogenize

the visitors, to keep them in a pragmatically manageable state that allows the workers in the hospital to function within their own and each other's expectations.

For women and their families who access perinatal care at the hospital, this institutionalization of caregivers can profoundly affect their childbearing experience. Hunter (2004) found, in the United Kingdom, for hospital-based nurse-midwives "the occupational ideology was 'with institution'" (p. 266) and their role "largely that of a nurse: carrying out doctors' instructions", with job satisfaction for some "measured in terms of organisational goals" (p. 268). Hunter notes that some of the junior hospital-based nurse-midwives found the discrepancy between their valued "'with woman'" ideal and the demands of the institution frustrating and alienating (p. 268). This contrasted with the community-based midwives she interviewed who "were more likely to work according to a 'with women' approach" (p. 266), spending time with women in their homes where "relationships with clients and their families assumed much greater significance" (p.268). It would be untrue to suggest by this that hospital-based perinatal nurses do not strive to develop trusting and positive relationships with the childbearing women for whom they care. Every nurse I interviewed spoke of her work passionately as being for the benefit of women and their babies. However, at the end of a twelve-hour shift, the relationship often ends. When the hospital units are busy, women receive less attention than the nurses want to give them. Schedules, co-workers needs and institutional responsibilities have to be attended to as well as their patients. Hospitals, then, can be simultaneously amenable and exclusive spaces. They may have their own inner communities, but are less 'of the community.'

Within the Community

What does it mean to be of the community, to be community-based? Community has been defined in many ways: by location; the sharing of important human attributes such as ethnicity, race, faith, values, sexual orientation, and intellectual interest; and by strong social ties. Community is the experience of belonging and support (MacQueen, McLellan, Metzger, Kegeles, Strauss, Scotti, Blanchard & Trotter, 2001; Miller, 2002). Community is much more than a locational context where relation may be experienced; rather, community is contextually relational. It can take place wherever people come together. Already it is clear that to be community-based as a perinatal caregiver is quite different from being hospital- or institution-based.

Community-based health care may be carried out in innumerable settings that are generally characterized as accessible places where clients have a sense of belonging by virtue of ongoing relationships with one or more caregivers who are located there, as well as with the others who visit the caregivers as they do. In the case of community health centres, store-front clinics, needle exchanges, pregnancy outreach agencies, and even midwifery practices these sites, in addition to offering one-on-one care, may be meeting places where clients have workshops, classes, or drop in for coffee and to seek social support. The shape of care and the way in which it is carried out is determined as much by individual clients as by a biomedical model or algorithms of health and illness management. Therefore the spaces of community care absorb something of the character of those who access them. Their appearances and situations are extremely varied and do not have the general, recognizable uniformity that institutional health care facilities wear. For example, one midwifery clinic I visited was in an old farmhouse with the remains of

an apple orchard behind it. When clients entered they were seated in the parlour, which was comfortably furnished and replete with toys to entertain older siblings. The main meeting and examination room was the kitchen, which in décor retained a homey 'chat-over-a-cup-of-tea' feeling. Another clinic was in a new, high-rise office building that contained the offices of physicians and dentists. Although this location resembled a typical physician's office in its anteroom, the meeting and examination room was furnished like a small, comfortable office-lounge. It contained a large couch – big enough for a woman to recline on to have her abdomen palpated and measured and her fetus's heart auscultated – chairs, coffee table and bright day-light from a couple of large windows. Appointments that took place in these settings were typically forty-five minutes to an hour in length; plenty of time for the midwife, her client, and the client's significant others to get to know one another and to build trust. Over the course of a pregnancy, these hours of meeting together, talking, working through hopes and fears for the birth, and facilitating women's growth into the profound experience of first or deepened motherhood establish a relationship between woman and midwife that can transcend the site of birth (James, 1997).

For community-based midwives – as for community health nurses – the homes of clients and their families are where care and the outcomes of care are frequently focused, even if aspects of prenatal care and birth take place in a clinic and the hospital (Hunter, 2004; McGarry, 2003). Home visits were made by all the midwives I interviewed at various times, and often frequently, in the course of perinatal care. In the client's home the caregiver is a guest; she asks permission to enter and is the recipient of the hospitality offered by the client and family in their own way. For a caregiver this takes a

combination of humility, acceptance and confidence in her role. With the caregiver as a visitor the balance of control is tipped in favour of the client so that the caregiver must consciously work *with* her, she cannot rely on a professional role and the authority of an institutional site of care alone to give her permission to attend to the client. When with a client in her home, the caregiver can more easily be present for the client alone rather than also attending to the distractions of a large and bureaucratic workplace (Lock & Gibb, 2003). This experience of addressing the client in her uniqueness within her own milieu, or one that she has specifically chosen, challenges the caregiver to creativity and more autonomous practice rather than constraining the scope of care offered (Baston & Green, 2002; Hunter, 2004; McGarry, 2003). Care can be negotiated to accommodate the client's every-day life in the context of those she lives with, children and adult family members, and even pets, in the space, clutter and rhythms of individual preference and habit. This maintains an environment where clients can mobilize freely, act and make decisions for their own comfort and about their care with confidence (Baston & Green, 2002; Lock & Gibb, 2003; McGarry, 2003). In this regard informed choice and community-based care are natural partners. And when combined with ongoing continuity of caregiver, as in the midwifery model (College of Midwives of British Columbia, 1997), women can be facilitated to embrace childbirth, wherever it occurs, in their own ways, bringing their children into the life of the relational community with a sense of power and accomplishment.

Gathering Lived Experience Descriptions

Data for this study were collected in the form of lived experience anecdotes and accounts that were described by the participants in the course of conversational,

unstructured, one-on-one interviews. Although close observation was originally to be an additional source of data, only two of the participants, one nurse and one midwife, agreed to have me shadow them. Nevertheless, my own extensive experience as a hospital-based perinatal nurse, as well as a month long practicum with a community-based midwife and her colleagues in British Columbia completed during my PhD studies, deeply enriched my insight into, and imagination of the phenomena of practice and the care provided within these two professional contexts.

The unstructured interviews solicited "personal life stories" relevant to the research questions (van Manen, 1997a, p.67). They were conducted at the participant's convenience in locations of their choice. The interviews were audio-taped and all but one, which was approximately three hours long, lasted from one and a quarter to one and three quarter hours. The content of the following questions and prompts were used to guide the interviews and to encourage the telling of participants' lived-experience narratives:

- Tell me about your background, education and some important experiences that led you to become a perinatal nurse/midwife.
- What are some experiences of caring for women prenatally/during labour and birth/during the post partum period that really stand out for you?
- Tell me about an incident or series of events where you know your presence and actions made an important difference for a woman you cared for.
- Thinking of a specific woman you have cared for recently, tell me about the care you gave and some of your conversations with her.
- Tell me about an experience of providing care to a woman you found easy to like and be with/difficult to like and be with.

- What are some experiences you have had in interaction with a community-based midwife/perinatal nurse in the hospital context?
- What are some experiences you have had in sharing the care of a woman with a community-based midwife/perinatal nurse?
- Have you had any experiences of informal knowledge exchange or teaching and learning with community-based midwives/perinatal nurses?
- If you worked as/worked with a midwife before regulation, in what ways, if any, have the registration and hospital privileging of midwives affected your experience of interaction with perinatal nurses/community-based midwives?
- What to you is the essence of perinatal nursing/midwifery? Can you tell me of an incident that illustrates this?

A single transcriptionist transcribed all of the tape-recorded interviews verbatim. I 'cleaned' and corrected the transcripts by comparing them as I listened to the corresponding audio-tapes.

After each interview, I reflected on the conversation and the participant, journaling what stood out for me in what was said. This included impressions that evoked the uniqueness of the person, her habitus, way of speaking, as well as recurring themes in her comments, and aspects of the location chosen by the participant where our conversation took place.

Reflecting and Writing

Study data, the anecdotes and accounts collected, are all in textual form. These texts have been analyzed for their thematic structure using the approach described by van Manen (1997). Themes are meaning units that offer insight and deepened understanding

of the nature of the phenomenon of interest. In general, the steps that were used are as follows: (1) the transcripts and observational notes were read and reread in order to apprehend their holistic meanings relative to the research questions; (2) the text was searched for key phrases that revealed something particularly vital to the phenomenon in the experiences described; and (3) each sentence or meaningful sentence cluster was explored for what it revealed about the phenomenon. The essential and incidental themes in the text were identified. Essential themes are those elements in the meaning structure of the phenomenon that if deleted leave the phenomenon incomprehensible (Spiegelberg, 1982; van Manen, 1997). Incidental themes also contribute to the meaning of the phenomenon but are not fundamental to its meaning structure. Recurrences and relationships between themes were noted and thoughtfully explored until a full and exhaustive description of the phenomenon arose based on what the data have to offer. Van Manen's four existentials (please see above) served as a guide for seeking full, concrete and detailed phenomenological understanding of lived experiences in the text.

Once the thematic structure of the phenomenon began to show itself, the essential themes were illuminated through the thoughtful selection of specific pieces of the text. The participant excerpts presented in this dissertation are verbatim from the transcripts, except where minor editing has been done to protect participants' anonymity or for clarity. The analysis of these excerpts is the result of a process of reflection and evocative writing and rewriting in order to highlight the most potent thematic aspects in the participants' words. In addition, this analytic writing focuses on the mantic nature of the experiences presented; that is, it seeks to call up through literary description a response in the reader that "devines and inspirits our understanding" (van Manen, 1997b, p. 346).

The participants' words, in this sense become iconic, allowing the essential meaning structure of the phenomenon to shine through the layers of lived human experience.

This process of reflection and writing has been to seek phenomenological understanding by remaining grounded in "the things themselves" (Husserl, 1965, as cited in Burch, 1991, p. 33), that is, what is given in participants' words. This task has been a challenge for me because of my perinatal nursing experience and friendship with midwives. The familiarity for me of what participants' words described has perhaps at times covered over as much as it has uncovered. Participants' stories, told with intensity and great feeling in many cases, conjured in me vivid images, emotions and a deep sense of empathy because of the common nature of the particular professional life-world in which we have worked and interacted with others. It has been difficult for this reason to refrain from presuming to know what participants and those in their anecdotes thought, felt and intended, even when this information was not provided directly by the participants. However, such an attempt to explain in terms of such psychological understanding cannot be an intent of this research. No matter how familiar I may be with the types of situations described, their settings, and the professional assumptions that shape them, my knowledge of other individual selves is inevitably only inferential and cannot help but be interpretively coloured by my own subjectivity (Burch, 1991). My subjectivity is present in this work to the degree that I am the hermeneuticist seeking to bring out meaning in the accounts, but hopefully this subjectivity is based primarily in the intersubjectivity of the shared life-world, not the projection of my subjectivity into the selves of others. Burch (1991) clearly articulates this difference between phenomenological and psychological understanding in the following:

> The principle aim of phenomenology and its chief contribution to all such ventures is not to recover subjective expressions and intentions, but to disclose and explicate the underlying intelligibility of lived experience. It is not the individual psychological subject, but a truth which precedes and makes possible anything subjective or objective, that phenomenology truly seeks. Because of its interpretive distance, phenomenology can show us dimensions of the hermeneutic situation and its "common sense" concealed to those who actively share it. Indeed, in this disclosure lies its pedagogical value. But phenomenology does not put us inside another's head. In this respect, its task is to disclose the truth of selfhood, not to engage a particular self. (p. 48)

Nevertheless, because the phenomenon being explored is relation, and because the relationships between nurses and midwives as shown in participants' account are tenuous and uncertain, I have explored through questioning the possible emotional and cognitive responses to certain situations. However, I have striven not to attribute feelings to participants directly unless they are shown in the participants' words. Ironically, there are times when the participants describe how they themselves second-guess those around them, presuming to know what is being thought, felt and intended. As will be shown in the following chapters, this can be the source of interpersonal conflict, and is also a necessary and intuitive practice for nurses and midwives in order to engage empathically with those for whom they provide professional care.

Evaluating the Strength of this Study

The purpose of hermeneutic phenomenological inquiry is to foster understanding about human lived experience. The preoccupation of the interpretive researcher is "not how to know the truth, but rather how experience is endowed with meaning" (Sandelowski, 1991, p.165). For this reason the concepts of reliability and validity as they are applied to quantitative or natural science research are irrelevant to interpretive inquiry. This does not mean that hermeneutic phenomenology is not rigorous. It is very rigorous in its attempt to explore and communicate the uniqueness and significance of phenomena; it strives "to construct a full interpretive description of some aspect of the life world" knowing that a complete understanding is ultimately impossible (van Manen, 1997a, p. 18). Likewise, 'objectivity' in hermeneutic phenomenology is not a detached stance, but rather an intense orientation to the phenomenon that gives it full attention.

The scope of this attention, however, no matter how thorough and one-pointed, is inevitably shaped and circumscribed by subjectivity; the experience and history of the researcher. The researcher's own human experience and the sources of knowledge and sensibility available to her are called upon in order to mine the richness of the phenomenon (van Manen, 1997a). So, rather than 'bracketing' my subjectivity, "I let my preunderstandings fully *engage* this text; I must let them be brought fully into play and therefore risk that they might be changed" in confronting a deeper understanding (Jardine, 1992, p.57). Even so, the interpretation of the phenomenon offered by this study, as revealed in the lived experiences of nurses and midwives, is not concerned with *my* experience and what I bring to an examination of the phenomenon. It is about the phenomenon itself to which I, like others, recognize a personal response and resonance, a

questioning and wonder. Part of the ongoing questioning relates to my own need to critically examine my certainties and thought habits, the impulse to label or dialogue superficially with the data through an appeal to conceptualization and theory. For example, a critical feminist approach to analysis could easily have been taken, or analysis based in the Foucaultian hermeneutics of power. Although there is acknowledgement of such conceptualization where appropriate, I have resisted the temptation to achieve explanation in this way, which seems to already gloss over the terrain of individual lived-experience in favour of a more distanced and generalizable understanding. In addition, throughout the process of completing this research I kept a diary of my thoughts, questions of the text and of myself as researcher. This process helped me to track my understanding of the meaning in the participants' words and recognize the phenomenon as it revealed itself.

There has been lengthy debate in the literature regarding criteria by which the rigour of qualitative research should be judged (e.g. Davies & Dodd, 2002; Leininger, 1994; Lincoln, 1995; Morse, Barrett, Mayan, Olson & Spiers, 2002; Rodgers & Cowles, 1993; Sandelowski, 1986, 1993; Tuckett, 2005). Many of these authors, although acknowledging the fundamentally interpretive nature of qualitative research, ultimately appeal to quantitative conceptualizations of rigour in seeking one set of validity criteria for its evaluation (Rolfe, 2006). As Sandelowski and Barroso (2002) suggest, the scope of qualitative research is perhaps too broad to be meaningfully represented by a single epistemic set of criteria. I have chosen van Manen's (1997a, p. 151-153) mode of evaluation for the strength of this study: I have sought to keep the text strongly oriented to the phenomenon of relation, richly evocative of the participants' lived experience of

this phenomenon, and deep in exploring the ethical and ontological meanings illuminated in this experience.

The ability of the phenomenological description presented here to evoke the experience of interprofessional relation between nurses and midwives was supported when preliminary findings related to their interaction were presented at two Canadian conferences, one attended primarily by community-based midwives (Zimmer, 2004a) and the other attended primarily by hospital-based perinatal nurses (Zimmer, 2004b). The value and strength of the research will be in the extent to which it evokes a similar resonance in readers, causing them to reflect, question, gain insight, and act with deepened understanding and greater relationally ethical awareness as a result of confronting the phenomenon of relation as it is presented in this text (Jardine, 1992; van Manen, 1997a, 1997b).

Ethical Considerations

Before recruiting participants and beginning the formal data collection process, ethical approval was obtained for this study from the University of Alberta Health Ethics Review Board, from Provincial Health Authorities within which recruitment hospitals were located, and in two cases from hospital research ethics review boards. All participants provided informed consent before engaging in the research.

Participants shared very honestly their personal experiences of relational interaction. Any anxiety or vulnerability caused by this has been addressed by strictly protecting participants' confidentiality and anonymity. Only I as the researcher, the transcriptionist, and my dissertation co-supervisors had access to the tape-recorded

interviews and/or original transcripts, each of which were designated and identified by a participant number. In this way my dissertation co-supervisors and the transcriptionist were at no time able to identify the participants by name. Participants have all been given pseudonyms in the lived experience anecdotes and descriptions included here. In addition, any personal names used in the participant's narratives have been expunged or replaced by pseudonyms. The only exception to strict maintenance of anonymity and confidentiality is in Chapter Seven where I have included the accounts of a nurse and midwife who spoke of the same incident. Only these two individuals would be likely to identify one another in the specific anecdotes related by them. I have kept all raw data and documentation, including consent forms, audio-tapes, field-notes, and original transcripts in a locked storage area when not in use by me. Consent forms identifying the participants with their numeric designation will be destroyed when this study is approved by my dissertation committee.

I am very aware that the anecdotes and accounts that comprise this inquiry are highly charged with emotion. Relation and birth are inevitably emotional phenomena. In selecting the excerpts from the transcripts my intent has been to show relevant facets of the phenomenon of interest. Descriptions that express anger, frustration, hurt or apparent insensitivity, as well as joy and compassion are abstracted from the whole and dynamic range of participants' accounts. Such selections are not in any way intended to comment on the character of individuals, either the speakers or those spoken of.

In the next chapter we turn to participants' lived experiences beginning with perinatal nurses' and midwives' stories of caring for childbearing women. The nature of

perinatal nursing and midwifery is illuminated in these accounts, as are the life-worlds of their work that situate and shape the character of their relationships with women.

CHAPTER FOUR

IN RELATION WITH CHILDBEARING WOMEN

In order to gain a deeper understanding of the meaning in the experiences that hospital-based nurses and community-based midwives have when working together in the care of childbearing women, it is important to explore their experiences with childbearing women separately. Their stories give insight into the love and concern they share for women, babies, and families but also illuminate some of the crucial differences between their contexts of practice and the disciplinary epistemologies on which they draw. Some of these differences are evident in the anecdotes of nurse Jenna and midwife Leona presented in Chapter One, as is their shared commitment to the women and babies for whom they care. Here I will show the ways in which these caregivers engage with women and establish trusting, mutually respectful relationships that are transformative for both woman and caregiver. These experiences help to contextualize their practices and professional identities providing a basis from which to consider, in following chapters, their interactions in the hospital setting.

The word, 'midwife,' means 'with woman' (Hoad, 1996; James, 1997). To be *with* someone suggests a relation of companionship, support and assistance. A midwife then is someone who shares in relationship, is with, the childbearing woman during her experience of pregnancy, birth and transition to motherhood. This companionable relationship of help and support is reflected in the additional use of the word 'midwife' as a verb; to help bring something into being (Simpson, 1989). Service is suggested here but with patience and a degree of passivity in that the midwife assists the active other and is

directed by her; she stands beside the woman in her experience of birthing. The midwife's role as primary caregiver throughout pregnancy, birth and the postpartum periods is to be with and assist the woman to bring her child into being, concretely and as a being-in-relation. As will be shown in the participant excerpts in this chapter, the work of midwifery also assists the woman to bring herself more fully into being.

The word 'nurse' also has meaning as a noun and a verb. A nurse is defined as a person with particular training to care for those who are ill or infirm and who may dispense advice and minor medical treatment (Simpson, 1989). The implication of illness is noteworthy, particularly in thinking of perinatal nurses who, although they do care for women with pathological processes during pregnancy and the puerperal period, most often care for women who are well and going through a healthy, physical and developmental process. Relationship is in this definition, but not with the implied proximity that the word 'midwife' provides. However, as a verb 'nurse' has a more specifically relational implication meaning to give careful treatment and attention to; to foster; and to feed another, or be fed, at the breast (Simpson, 1989). Etymologically 'nurse' is related to the words nurture and nourish (Hoad, 1996) connecting the meaning to mothering or parenting activities. Although all of these activities must take place within relationship, they speak more strongly of doing 'to' or 'for' rather than 'with' the other. The meaning of 'nurse' in this regard is more service oriented in its meaning, more altruistic perhaps, than is the word 'midwife.' Nurses do fall under the euphemism, 'public servant.' The perinatal nurses in this study are employed by public institutions, hospitals, and so must accept into their care any childbearing woman who comes to their

door. It is here that we begin to explore these caregivers' relationships with childbearing women.

Nurses: At the Threshold – Welcoming and Engaging

The nurse and woman meet, in most cases, as strangers at a time of tremendous significance for the woman and her loved ones. The woman initially arrives at the threshold of the hospital to enter into a foreign microcosm. The nurse is the first to greet her and to respond to her need in coming. It is the nurse's responsibility to learn and integrate a great deal of factual information about the woman physically and psychosocially as well as gain an understanding of her personhood and the meaning for her of the coming child. This must often take place within a very short time period, particularly if the woman is already actively labouring when she arrives at the hospital.

Opening to Connection

Nancy shows how she greets the women who come to her by the chance of their arriving. She and they do not choose each other. The women have not personally engaged her as a caregiver. Knowing this, and knowing her own responsibility, Nancy seeks to connect them with the bridge of shared human experiences.

> I try always to be very positive. I'm very open. I'm warm. I ask questions to try to get to know them quickly. Probably very personal questions, but you sort of get into that part as quickly as possible. And I share things about myself that I think will help them connect to me. If I need to I'll talk about one of my pregnancies, or my family, or where I'm from, or any kind of background that will help make a

connection so that they can see the similarities in our lives. (Nancy, perinatal nurse)

The personal questions that Nancy speaks of are in large part those used to ascertain the physical and psychosocial information she needs in order to give appropriate and supportive care. How is it that women will respond when nurses like Nancy ask 'very personal questions' shortly after meeting them as strangers? What contributes to this degree of instantaneous trust? Undoubtedly the semiotics of the hospital setting and the nurse's appearance and confident manner contribute. But there are other kinds of communication taking place that reassure the woman. The directness and openness of Nancy's warmth, acceptance and welcome invite the woman into relation. In this setting she is the host and she accepts this role without question, seeking to connect with the woman by sharing of herself in a personal way. This disclosure is an acknowledgment of the vulnerability that the woman may be feeling, a sympathetic reciprocation. It is a gesture that helps to dismantle the power the nurse holds by virtue of her professional position and clinical knowledge. Her position and knowledge are the tools with which she is capable and responsible to reductively analyze what is presented in the behaviours and physical parameters of the embodied woman before her in an objective manner (Gadow, 1995; Bergum, 1994). However, Nancy' self-disclosure is an invitation, the first tacitly expressed question in a dialogue between herself and the woman, that allows the woman to assist her in situating this abstract information within the woman's own framework of personal meanings; that is, to bring what Bergum (1994) and Gadow (1995) refer to as inherent knowledge to the care that will be given and received.

Embodying Welcome

The nurse's focus on the woman's material body – an aspect of any healthcare encounter that may increase a patient's feelings of vulnerability – is eased by the nurse's consciousness of her own body, voice and face. As the following shows, she may intentionally present herself in a way that will emanate safety and welcome into the hard, unfamiliar, clinical environment.

> One part of establishing a relationship is through body language. Definitely body. I think of facial expressions, of smiling, eye contact; looking at them makes them feel like they are a worthwhile person. In that situation I try to consciously relax myself, relax my voice, talk a little bit slower, soothing, because they are a little bit nervous. I usually try to say things that they are probably feeling and maybe don't want to say, like they're nervous or excited or worried about the pain that's going to come. I get in there and I try to allay some of their little worries right away. And I ask them about whether they're ready for the baby; the room and names and, you know, all these little things. It may seem kind of silly, but, you know, that's all really important to them because their whole life is focused on the baby right now. (Rhonda, perinatal nurse)

Inherent knowledge, as described above, is gained through engagement with the other. Relational engagement involves being present to the other as a whole person, mind and body. The communication of bodies in proximity is powerful but easily denied, particularly with strangers, in our culture and language where bodies are dualistically split off from the cerebral subject self (Bergum & Dossetor, 2005, Irigaray, 2002). Bergum and Dossetor (2005) suggest that awareness of ourselves as body and mind,

emotion and rationality, and an awareness of how body and mind can speak coherently together, can change the shared location of meeting, creating a relational space in which we are fully present, engaged, with others. The space then becomes a space of community and connection where we recognize one another as whole. Rhonda's words above express this understanding. She shows empathy for the emotions of the woman who has presented herself, and through her embodiment gives permission for the woman to be wholly herself, at home in her feelings and physical experience.

Hospitality

At-home-ness includes having one's human needs met and experiencing a sense of comfort. Nurses as those who tend and nurture others are in a particular position to create a sense of at-home-ness with their patients through their actions and engagement, in spite of the very un-homelike hospital environment. This seems particularly important for childbirth, the welcoming of a new person into the heart of a family. The following excerpt shows how one nurse embraces her role as host, how the making of a hospitable relational environment is accepted as her responsibility.

> Overall it's a pleasure – even if you don't particularly bond with the lady and her husband as they come in – still to be there is wonderful. You have to make people feel comfortable immediately... You assess them very quickly with your eyes because that's a nurse's best feature. And I often use humor because most people will respond to that. It's not threatening. It puts them at ease. You support the couple in a lot of ways... it's more like an art form or intuition, I don't think it's a skill, and I don't think it's scientific. You have your personality to work with. And you have to be welcoming, because I've always felt that patients that come

into the hospital, they're on your turf, so you welcome them like you would a guest. Nothing is too much trouble. And I give...no wonder we're drained after; we give so much of ourselves and our own emotion. And the patient is looking at me, and I want everything to go well, and I'm really super, super involved. You have such a sense of satisfaction that I don't think you can get anywhere else. (Deborah, perinatal nurse)

The philosopher, Levinas, writes of an ethics of responsibility for the other. In this, he says, we are called by the face of the other who stands before us in the nakedness of their humanity. This call is a call to responsibility to be for them, an obligation toward them that is absolute without thought or valuation of significations, status or identity; an ethics that precedes ontology (Levinas, 1994). The acceptance of this responsibility is in the welcoming of the other, in hospitality towards them (Derrida, 1999; Levinas, 1969). In Deborah's words we hear this commitment to the other, and not only the acceptance of responsibility; there is also pleasure for her in taking up this obligation as a host. As Peperzak (1997) says of Levinas ethical imperative, "Being-for is being a body, having hands as well as a heart: it is building a home in which warmth and meals are available, and so on. I cannot be for-the-Other if I do not enjoy the world." (p. 200). For nurses, who foster, comfort and heal with their hands as embodied presences, these words have particular resonance; welcoming the patient with pleasure at the possibility of providing hospitality, nurturance and relation.

Giving all the Care

The reality for nurses and the women they care for is that they do not always connect in recognizable ways in mutual relation. This is not surprising when the

astonishment, fear and lack of control that some women feel in experiencing the power of labour is considered. Deborah describes how she attends to a woman with whom she is not able to establish an initial harmonious bond.

> When women come in with whom I don't really click, or when I don't find that my sense of humor is going over well, I just give them *all* the care. You still give them *all* the care. You know I'm gentle and maybe it's just because they're tense. Maybe she and her husband are having problems. And sometimes they are just so afraid. And so then you just say, "All right, I see what you are going through, you are very scared, you're very anxious, you're very nervous. Did you go to prenatal classes? Do you have any idea of what is going to happen to you?" Especially women with their first babies; they have no idea; they didn't expect this amount of pain. So you do the simple explanations and you give them all the physical care and then slowly their level of defense drops. So you may never be totally close to them but they will kind of let you into their world. (Deborah, perinatal nurse)

Here Deborah shows the way in which nurses may express relation with women by allowing their actions rather than their speaking to initiate and carry on a dialogue in which they learn about and respond to the woman's needs. Her description shows patience and compassion, which is expressed in her conscientious embodied doing. However, Deborah also evokes a feeling that this is challenging work, emotional work. Her words are not at all begrudging, but rather show her focused involvement. The woman's pain and anxiety seem to temporarily become her world. Deborah is present with her there. As Cameron (1998, p. 203) says of nurses and patients, "Lived pain affects lived relations. It refashions them and pulls them too into the immediate, the 'very

now.' Those in intimate bodily relation are pulled into this contingency too. A change in one effects a change in the other." From the first moments of their encounter, Deborah immerses herself in the experience of the woman she is called to care for. She attunes her action and her words to the woman's needs, honing them with sensitivity and embodied empathy to meet and touch her precisely where there is fear and pain.

Nurses: Negotiating Labour

The women who choose to birth in the hospital under the primary care of a physician, and those who have been advised that they must birth there due to factors deemed to put their childbearing at risk, enter into a world that is the materialization of Western scientific theory. An aspect of this theory is the construction of women's bodies as objects, unruly and physically problematic. Murphy-Lawless (1998) argues that scientific tenets, texts, norms, statistics, and practices that have taken this assessment of women as 'truth' are what shape modern childbirth, rather than women's lived experiences. Women's disappointments and desires have little purchase in either obstetrical theory or practice. Moreover, the obstetrically constructed experience "is made to appear ordinary and normal" (p. 32). The ongoing acceptance of medically mediated childbirth unwittingly reconstitutes that reality. Nevertheless, the vast majority of women in Canada do have their babies in the hospital setting. The care they receive there, except for very brief periods of time, such as when a physician comes to catch a baby at birth, is entirely given by nurses; and so it is nurses who interpret, and in their relation transcend, the medical environment for women.

The perinatal nurses stories about their experiences with women during labour are deeply infiltrated with obstetrical technologies and the culture of the hospital. Nevertheless, what stands out is the nurse's ability to be with the woman moment-by-moment, deeply attuned to her experience, experiencing it along side of her. And yet also able to hold future potentials and eventualities within her sight, revealing them to the woman as needed and appropriate.

> Sometimes the woman will come to the hospital with a birth plan and she wants absolutely no intervention at all. Then, when intervention is necessary, she needs good explanations around that. She needs to understand why I'm saying it's necessary; and generally she'll say "yes" to it unless it presents a risk to her baby. I usually talk about that too. For example, if she definitely doesn't want a forceps delivery or a caesarean section, but she knows there might be an emergency situation where that becomes necessary, I'll explain what would happen in that case. She'll usually say, "Oh yes, of course." So I kind of prepare them for the worst-case scenario so they know what to expect and they feel that they have been a part of that decision. I have women come through labour and delivery with almost everything on their birth plan crossed out – it didn't happen. But you go back the next day and they're just beaming and feel they were so cared for. I remember one woman who said, "I was so supported. Even though I had a forceps delivery, and a third degree tear, and the baby couldn't go to breast because he had to go to the nursery, and nothing happened the way I wanted it to, I still feel good about my labour." I think, isn't that amazing! Why would she be feeling that

way? It's because she *was* cared for, she was included in every decision. She felt that everything was done for a good reason and had to be done. She felt so good about it. And I find that's a wonderful statement of care when that can happen. They can go home feeling this was a good birth. (Kathleen, perinatal nurse)

Kathleen's account is full of hints of risk and danger and yet it is a happy story, one she tells with triumph on behalf of the woman. Her sense of responsibility to both protect the woman and her baby from harm, and respect the woman's autonomy is very clear. In doing this she weaves a time-web connecting the present situation where the woman and fetus are safely held and casts threads out to possible future events, some more and some less desirable, linked by various contingencies. She holds this web out for the woman tracing each strand of possibility, describing, explaining, so that over the intervening hours the woman can trace her own progress and choose the best thread to follow toward her baby's birth. This nurse's caring upholds the woman's power and supports her coming into motherhood with confidence and joy.

Creating Hope

As with Jenna's story in Chapter One, there are times when emergencies arise and there is little the nurse can verbalize for the woman and her partner that will explain or include them. They become lost from the birthing process and disempowered by the chain of events regardless of the nurse's intention to keep them informed and free to make choices.

The dad is afraid, he's afraid for the mom, and afraid for the baby, and he's just told, "You wait here." "Well what's happening while I'm waiting here?" It's hard for them. And they probably feel quite helpless wanting to do something...

Sometimes *we* feel that way and we *know* what's happening. But you're helpless to stop the train. It's moving and you have to move with it. All you can do is explain as quickly as possible. And sometimes all I can say is, "It's going to be okay." Just hold their hand for a minute, look at them and say, "It's going to be okay." And hopefully they have developed enough trust in you that they can look at you and say; "Okay. It's going to be okay."

I've had a few situations where there is a horrible fetal heart rate and I'm looking at the monitor strip feeling like I'm going to throw-up. Obviously we have to get the baby out as quickly as possible. Things move fast; and at the end the patient says to me, "You didn't look worried. You didn't look worried at any time so I didn't feel afraid because you didn't look worried." And I think, good! That's my goal, not to look worried, not to look afraid. Because they sometimes look so intensely at you, to reach you, and if you've got that 'oh my god!' face on, then they're going to panic. Right? So you have to have that 'everything is going to be okay' face on and really hope that it is at the end. (Nancy, perinatal nurse)

In the situations Nancy describes there is no time to provide information or clarify options. There is no web of contingencies. The options have narrowed to one, get the baby out now! Despite her sudden preoccupation with the emergency, Nancy still attends to her patient's experience. Although focused on prepping to go to the operating room she composes her face and words to reassure the woman and her partner. She does not know the outcome, but her words express an impulse to give them hope. In the intimate embodied acts of nursing the nurse becomes a buoy for the woman and her partner, a beacon to which they look for light and guidance away from fear. Her acts in the event of

crisis hold the couple and their unborn child central; and her hope is with theirs in the safe birth of a healthy child.

Advocating for the Best Care

When labour is progressing relatively smoothly, with her attention so filled by the labouring woman, any external impediment to the patient's progress and comfort, to the hospitality the nurse has offered and seeks to uphold, can arouse a tigress of advocacy and protection in the nurse. The poor communication and coordination of team members and the cumbersome machinations of institutional policy can occasionally pose such impediments.

> I find it frustrating sometimes here; the residents need to learn various skills, for example vaginal examinations. So, when the woman needs to be examined for progress, you are supposed to ask the resident to come in to do the examination. Now, if a woman needs pain medication, she has to be examined so you know what analgesic you can give, and of course, you need a physician's order to give it. But sometimes the residents are busy, so you may end up waiting around for the resident to come and do that vaginal exam. It makes the exam sort of separate from caring for the woman. The 'expert' has to come and do this, so now we just have to wait. I hate that. I would – and I do – go ahead and examine her if the resident can't come right away. And if I can't get an order from the resident right now, I will phone the family physician and get an order. I haven't gotten in trouble for doing that, but I have sort of got 'the eyebrow.' "You did what?" I say, "Well, she needed pain management now. We have tried everything else and she has coped beautifully, but right now she needs her Fentanyl [a narcotic

> analgesic]. And I am not going to wait an hour to give her that, because that is not good care for my patient." I am really used to working independently so I continue to manage the care of my patient to her benefit and to work with the system as best I can. If the system is failing her, then I will find another way to provide care for her. We just have to. (Kathleen, perinatal nurse)

Nurses are often very resourceful in providing what patients need by circumventing institutional policies and protocols (Goldberg, 2004). Kathleen, as a dweller in the hospital, knows the maze of its hierarchy and negotiates the personalities and structures with relative ease. It seems incongruous that the birth of a baby, something so fleshly and human, should take place in such an inorganic environment. Yet it is the acts of commitment and advocacy extended by nurses like Kathleen to women who come to the hospital as a place to birth that mitigates the solid impartiality of the institution. Her words indicate an intensity that is one-pointed and this-woman-centred in her attempt to give seamless coherent care. She seems to give her whole being to this one relation in an immediacy almost like that of a mother to her child. Her advocacy is not based in law or codes of ethics, although these would be present in the background for her as a registered nurse. She shows what Gadow (1980) calls existential advocacy guided by her attention to the whole person of the woman, as a whole person herself. The focus of this relation is, in a sense pedagogic (van Manen, 1997a), in that the being of the woman and the evolving events of her labour call for response from the nurse. The woman's body poses questions and demands, and the nurse in turn provides care and watchful knowledge of the labour's unfolding events, offering resources for the woman to help her to labour well.

Advocating for Respect

Nurses may also find themselves advocating for the women in their care in regard to aspects of their everyday lives outside of their brief sojourn in the institutional milieu. Nursing the whole person requires that attention and commitment be extended to address more than just the immediate bodily urgency of childbirth. The moral space of birth that the nurse helps to create through relation within the hospital context extends out with the woman into her life-world. In her immediate work during labour the nurse is also attending to the inner strength and wellbeing of the woman and the supports available to her that she will call on throughout her life as a mother.

> Family members and husbands loom large in some experiences. Oh absolutely, very, very much so. And certainly there are lots of times where I've had the experience of feeling at odds with the husband and I suddenly find myself advocating for the wife. For example, he may be passing judgment on her behaviour, or whether or not she needs pain medication, or on whether labour is a big deal or not. And I mean, I make a joke of it quite often. I'll say, "You better just remember, this is a woman's world, and, you know, you are outnumbered here!" But, you know, usually I try to sort of help them understand that this is a situation that they need to respect. If I'm feeling like they're not respecting what is going on, then I have to put in my two bits worth for women. I may stand back from that situation and think, "This is a bit bizarre. I don't know this woman. I don't know anything about either one of you. But I am feeling like I need to protect your wife from you." I've had that dynamic. (Vivian, perinatal nurse)

Extending hospitality to the woman and her baby, and to the family into which the baby comes is immediate, but the welcoming work of the nurse reverberates out into the world and contributes to the woman's sense of comfort there, beyond the brief shelter of the hospital. Vivian states, "I don't know this woman." She cannot know the daily vicissitudes of her life or all the details of her lived history. However, inherent knowledge of the woman, gained through embodied sensitivity, can alert the nurse to shadows of anxiety, low self-esteem, and fear, signs that the woman is not happily at-home in herself. Some of this knowledge is also gained by observing interactions between the woman and her loved ones, sensing the vibrations in the relational space between them. In this situation Vivian speaks of respect, the need for respect by the husband for the ineffably phenomenal work of the woman in bringing a child to birth, and respect for her as person. This respect for the person of the woman is central to the perinatal nursing relation and helps to bring the woman to a place of epistemic worth (Goldberg, 2004) in the eyes of others.

Reflecting Her Worth

It is not always easy for the nurse to find in herself respect for the woman. However, this is, again, a part of the responsibility of extending welcome that nurses embrace. Nancy describes a not uncommon situation that calls on the deep ethical commitments of the nurse.

> When we have drug-addicted patients some of the nurses say, "I don't want to deal with her." You know, because they can't understand where she's coming from, she's out doing drugs instead of caring for her baby. It's frustrating. But if you can show that person some caring it will help them for an hour, or a

day...Just show them that respect because that's what they don't have. If we show them that they're worth something, "I respect you," then it does help them feel better about themselves. And then the relationship becomes much easier. That's the way I'd like it to be every day. But it isn't. And there are patients I don't like but it doesn't mean that I don't want to help them. I think that's why I never just turn my back on somebody and say, "Well, if you don't want to listen to me, just forget it." Even if they don't want to listen to me, that's okay. It's hard, but it's okay. (Nancy, perinatal nurse)

Nancy speaks of respect here as worth, both self-worth and acknowledgement of another's worth. Where does the nurse find the resources to see as worthy someone who seems to violate the things the nurse values most; the coming child and responsibility as mother? This begins with knowing and respecting one's self, acknowledging one's own autonomy to live in the world with integrity to one's values; but not in a prescriptive or authoritarian way towards others; rather with humility, self-honesty that accepts and contemplates others' differences (Bergum & Dossetor, 2005). This does not necessarily erase the anger or sense of injustice a nurse might feel toward a mother who disrespects her fetus and herself. However, it provides a basis from which to open to the other unthreatened, to allow the space of judgment to be filled instead with genuine empathy and compassion. From this place, which is again a place of hospitality, the nurse may experience her encounter with the woman with wonder and concern, to seek the revelation of her worth rather than to condemn and withhold. Once found, the nurse, in the inconspicuous but sensitive ways of her caring can hold this valuing up before the woman so that she catches a glimpse of herself and of her inherent worth reflected there.

In their anecdotes and accounts the perinatal nurses in this study show themselves to be deeply committed to their work with women. They demonstrate an awareness of the effect that the institutional context may have on women's experiences and yet seek and succeed in transcending this through their focused and embodied concern. Notwithstanding the temporal and institutional constraints of the context in which they work, they succeed in providing a shelter of caring and relational engagement that assists women to birth safely and with a degree of self-empowerment. Welcome and hospitality, sharing of knowledge, empathy, existential advocacy and respect are all ways of being extended to their patients and within which these perinatal nurses live and act.

Midwives: Knowing that Women Can Do This

All of the midwives in this study spoke with delight and awe of the women for whom they care. Many told stories of women's transformation and empowerment through the experience of pregnancy and birth within the context of the midwifery relation. It was having this experience themselves that brought some of these participants to their chosen profession of midwifery. For others, it was the strength of women they encountered as fully embodied creatices that converted them to the midwifery way of childbirth.

My Body Would Know

Lauren came to midwifery because of her own pregnancy and birth experiences with midwives. The rediscovery of herself, born in the experience of birthing her children, was facilitated and nurtured by the company of the midwives who laboured with her and acted as companions and guides on her journey to empowerment.

When we got to the Kootenays, the women we knew there were all homebirth-midwife-friendly; everybody was using midwifery care, and it seemed reasonable to me. So I hooked up with a midwife and had my baby at home. And I just felt that my experience was so amazing and so empowering that I believed every woman should have that as an option. In fact I thought; why would anybody do anything else? Later we moved out to the coast. We went to live in a small island community where there was a midwife who was recommended to me. So I had baby number two at home with this midwife, and again, another amazing experience; just really empowering. I found this midwife to be a very inspiring woman; very, very gifted.

I think what made my birth experiences so wonderful and empowering was that the midwives that I worked with and I were like-minded. Maybe for other women it wouldn't be quite the same, but I believed that my body would know what to do. And I really did not want to be in the hospital. I had been politicized previously against the medical system by family illnesses. My father ended up dying at home after a drawn out conflict with the hospital to get him out of there. I just felt that birth and death both belong at home and I felt that my body would know what to do. I didn't want to be interfered with and I didn't want people taking my blood pressure or sticking needles in me or asking me questions or clacking with high heels down the hall, or any of that. It just seemed like the hospital wasn't the right sort of atmosphere. And the midwives that I worked with came very much from that conviction: 'believe in yourself; you can do this. Women have been doing this for centuries. The power is within you.' They and I

were singing the same tune. So I guess for me it wasn't that they empowered me, it was that I was on a path to empowerment and they were on the same path. And so that's why it worked out so well. So I didn't have any obstacles. I guess that was what it was; I didn't have to convince anybody that I could do this. (Lauren, midwife)

Lauren's relationships with her midwives coincided with a time of transformation for her, and she speaks of the second midwife in particular as a person by whom she was inspired. But what seems to stand out for her about midwifery in her experiences of childbirth was the freedom she was given to be herself, to follow her body, her convictions, and values. Davis-Floyd and Davis (1997, p. 316) suggest that women differ in their views of childbirth, just as those who attend birth do. For the minority of women who reject the "technocratization of birth", midwifery care is a logical and resonant alternative.

> Those women who most deeply trust birth usually place themselves quite consciously as far out of the reach of the technocratic model as they can get, choosing to give birth in the sanctity and safety of their own homes and grounding themselves philosophically in a holistic model of birth... Like the midwives who attend them, these homebirth women have no trouble understanding the value of connection; indeed, connection is the most fundamental value undergirding their holistic paradigm. (p. 316)

Women like Lauren choose to experience "the whole of birth – its rhythm, its juiciness, its intense sexuality, fluidity, ecstasy, and pain" (Davis-Floyd & Davis, 1997, p. 316). Once again we are presented with the theme of embodiment. There is no hint of fear in

Lauren's words; she speaks of her embodiment – women's embodiment – as the whole unit of the self.

Gadow (1994) posits that the social narrative of women's bodies is that of object, which never really belongs to or is integral to the woman herself. She says,

> This experience of herself as object is related partly to being the object of another's gaze. But the body's 'withness' is more fundamental than being looked at by the other. It is a watching of oneself, a watching out, a carefulness. One of its forms is a fear of getting hurt. (p. 297)

The medical narrative, Gadow says, takes this social narrative up and consummates it in absolute objectification, stripping the body of any interior subjectivity. Pregnancy and childbirth in particular bring these narratives together in the concept of risk in which the medical control of the body as object and the female body's inherent fragility are married (Gadow, 1994). Risk management is the rationale for hospital birth and for medical intervention in pregnancy and childbirth. It is necessary at times; but are those times as numerous as we are led to assume? Perhaps, for Lauren and the midwives who attended her the answer would be 'no.' Lauren as birthing mother, and as midwife, seems to have escaped or overcome these objectifying narratives of her embodiment. Here we see one of the major epistemological differences between the disciplines of obstetrics and midwifery, though not necessarily between individual nurses and midwives. Perinatal nursing, housed in the hospital, is embedded in an environment where risk and pathology are anticipated and where women are assumed to require the help of experts in detecting, naming and providing protection against that risk. The fact that the midwifery model of care includes women's choice of birth place (College of Midwives of British Columbia,

1997) indicates an inherent trust in women to come to knowledge of their own bodies and to make decisions based in that knowledge.

Birth Belongs to the Woman

Lauren tells a wonderful story about the homebirth of one of her clients that exemplifies this total embodiment of which some childbearing women are capable.

> Just recently we had a woman having her second baby at home, probably one of the most empowered women I have ever worked with. She had no tests done at all except having her blood type taken, no ultrasound, nothing else. She was doing a homebirth and she had a pool. And she was having all these people at her birth, the drum and chant and carry on. It was like a birth out of the sixties.
>
> There were two medical students here working with the GPs in the community, and they phoned me up and said, "Can we spend a day with you?" And I said, "Oh yeah, sure." And so that night one of the students called me and said, "So we're going to come and see you tomorrow." And I said, "Well, that would be okay, but I think I am going to have a birth tonight." "Oh can we come?" And I said, "Well that would be up to the woman," and it seemed a surprise to them that I wasn't the one that could say, 'yes you can come.' I said, "I'll ask her," and I said, "She has a very large group of people coming, but I'll ask if she would feel comfortable with you there." So anyway I did ask her and she said, yeah, they could come. So they came and I showed them our equipment and our set-up and what not. And they said, "What do you have for pain relief?" I said, "You're looking at it." They were standing right beside the pool. And they said, "This is it? I said, "This is it." They said, "What about Demerol?" And I

said, "Not here, we can't have a depressed baby born at home. No, this is it, just the pool."

So anyhow they stayed, and this woman was amazing. She danced and Tai Chi-ed and meditated that baby out. You know she was swaying her hips, she would squat for contractions, she would just get right into it. And in between contractions she would look at people in the room and just smile. She was radiant, just radiant. She was unbelievable.

At one point toward the end of her labour she was in the pool and I noticed some meconium in the water. And when her waters sort of broke more fully, I noticed a fair amount of meconium. So I said, "Well, I think you better get out." So she got out of the pool and up onto the bed into a position that made sense to her. It was sort of half side lying half sitting up. We have almost all our women put their own hands on their perineum to birth the baby. So she put her hands on her perineum and birthed her baby's head, and then I just helped a little bit with the anterior shoulder and she reached down and got the posterior shoulder and brought her baby up to her... So she basically birthed her own baby.

Well after this birth these two medical students were just in awe. They said, "You're kidding! How many births do you do that are like that?" And I said, "She is a pretty remarkable woman. She was very together. But in terms of women birthing their own babies, many of the births we do are like this." I said, "Women can do this. Women can do this." But they just couldn't believe it. And I thought, isn't it wonderful that they had the opportunity to experience this kind of birth early in their careers. They had seen a woman, a powerful woman, birth her

own baby in the company of friends. But I realize that with nurses and doctors in the larger hospitals, they wouldn't even know what I am talking about. (Lauren, midwife)

The tone of Lauren's story is almost that of an onlooker. However, the beautiful way in which she describes this woman as she laboured shows that she was deeply attuned to her, watching and monitoring the progress of the labour and this woman's experience of it. The woman journeyed through the labour in what is described as near ecstasy, moving forward on the corporeal waves of contractions and finally reaching down to birth her own baby. This description does not deny the fact that labour may have been painful; however, if it was, the woman seems to have met the presence of discomfort there in her body by dancing with it, partnering it until her goal was achieved. Her labour is described not as something that happened to her, but rather as a process that she invited and embraced.

There is no question that this birth belonged to the woman. Nevertheless Lauren was alert to the possibility of risk when there was reason to be and gave a simple direction that would allow her to assess without interfering with the woman's process unnecessarily. In this story both the woman and midwife have power. However, the midwife defers to the woman whose birth and body and story this is. When for a moment she must step in, there is no question regarding the woman's action in response. Bergum and Dossetor (2005) describe this respectful, trusting ability to heed one another with uncomplicated give and take as mutual power. Citing James (1997), they describe the midwifery relation as an example of this, "one where respect for choices of the pregnant, labouring, and mothering woman are paramount. Yet there are moments when the

midwife can say to the labouring woman, 'Do this now!'" (Bergum & Dossetor, 2005, p. 91). Lauren's relationship with the birthing woman in this anecdote elucidates this shared power. Even when discussing the birth with the medical students afterwards, she defers to the power and autonomy of the woman to create such an experience for herself.

Women Blossom

Iris, another midwife, talks about the transformative experience of the midwifery relation for some women. Women do not all mature with the intrinsic embodied understanding of themselves that Lauren and her client illustrate. Within the midwifery relation they may, for the first time in their lives, feel that they have the freedom and have been given the knowledge to make good, autonomous choices about their care.

> I just think as culture we have been so indoctrinated that this is a medical and surgical crisis. And it's not. It doesn't need to be. I would say, in our practice we probably do about sixty per cent homebirths, but at the booking visit [initial meeting] maybe only twenty-five per cent of our clients know that is what they want. What happens, and this is one of the things that I love: watching women blossom in the way they carry themselves, how they ask questions. I don't know – they just become more confident in themselves, they are more confident in the process. A classic example of watching these women blossom during pregnancy is a woman whose baby was born last July. She is from a fairly well-to-do Latin American family, and her mother and all her sisters have had caesarean births; all of them. And she fully anticipated having a caesarean birth too. She wanted it all; she wanted an epidural on that first contraction. Boy! But by the time she had the baby there was such a difference in her. She had a planned homebirth! That's

what I mean when I talk about it as being a *transformation*. It truly is. Stop me if I am babbling, but I feel passionately about this. If a woman can leave her experience, you know, have a baby, and feel empowered and confident, and "Hey, I did it!" rather than feeling not only physically, but emotionally, traumatized... I don't think it's an accident that in our practice we have very, very few cases of postpartum depression. I don't think it's a coincidence. (Iris, midwife)

The transformation that Iris speaks of witnessing is in the women; however, its source is in relation. This relation is between the woman and the midwife; but it is also the growing relation between the woman and her body, her embodied self. As knowledge between the midwife and woman of one another grows, and as the woman comes to know herself as becoming-mother, so trust has an opportunity to grow. James (1997) describes the trust between midwife and client as follows, "The woman trusts the midwife because the midwife trusts the woman" (p. 97). This mutual trust is key to women finding increased trust in themselves. Trust evolves over the time of their relating and flourishes in the woman's courage and feeling of entitled self-respect to question (James, 1997). Questioning is encouraged in the midwifery relation and truly informed choice about care is fostered. As the woman's body alters and she experiences the changes of pregnancy, the midwife encourages her to identify how this feels, to listen to the messages her body sends to her. Where necessary the midwife interprets these bodily mutterings and outbursts. However, as in the nurse relation described above, these interpretations are illuminated by inherent knowledge of the woman.

Within Herself

Marianne is a European trained midwife who deeply believes in the woman's ability and strength to bring her baby from her body herself, with little assistance, even from the midwife. She watches for the inward-turning that characterizes a woman in active labour who is working with her body's powerful rhythm.

> It's just something to do with the knowledge that is within the woman, and we just have to uncover it or let her get to her own abilities. We don't need much then, just ourselves. In hospitals here, childbirth is not practiced that way. Not even among many midwives. They still think they need to distract the women during birth. I mean, that is not how it works. One needs to focus and be within herself. To cite Michel Odent, he says that whenever he comes to a homebirth and the woman has locked herself into the bathroom, he knows everything is going to go well, because she is within herself and she doesn't need any help. So that is the best thing that can happen; the woman is just within herself. (Marianne, midwife)

Active labour, as I have witnessed it, is a trance-like state for many women achieved through the medium of their bodies. This seems to be what Marianne describes. Hormones send passionate messages to the brain and viscera. Muscle pushes the baby into the bony chute; fluids gush; blood and mucous slide down straining legs, sign that the cervix, the inner mouth, is slowly preparing to utter the new being. In this there is no obsessive fetal monitoring, no blood pressures being taken. Instead trust is given up to the woman. The midwife patiently, intelligently watches, supporting in proximity, in readiness, this amazing work.

Midwives: Being With Women

The midwifery relation as illuminated by the participants in this study is often very intense. It is not exactly a friendship, although very intimate information is shared by the woman with the midwife who often provides support far beyond that which would be given or expected of other healthcare providers. Midwives give sustenance, sustained presence-with, to the many women who come into their care, directing their particular eclectic knowledge and understanding to the uniqueness of each woman's way. Their words and stories spill out detailed images, mixed metaphors of bodily functions, medical terms, and human relating. They show unprecedented dedication to women and their families who hold them as deeply loved and revered wise women.

A Partnership

Pamela describes her relationship with her clients as a 'partnership.' Partnership denotes comfortable relation, but with purpose, such as a shared business or research venture; it suggests equality and work together. We also speak of our spouses or long-term lovers as partners. What word best describes the midwifery relation? The struggle to identify the qualities can be heard in Pamela's words that follow.

> It's the partnership with the women themselves. I am not anybody's boss, and nobody is my boss. It's a real partnership. You don't really see them as friendships in the accepted sense of the word. You definitely make a connection with people, and you are very close to people, but it's not the same as it would be with a friend where you see them socially. Because, I mean, we don't see our clients socially, unless they are friends to begin with. But they are a lot closer than acquaintances. But there is... I don't know... that professionalism. We certainly

do not get particularly familiar, because there is a need to maintain the respect for the woman and her family, and the recognition that you are the facilitator in this process; you are not the be-all-and-end-all for anybody. You know, you are there to help her and her family through this pregnancy, labour, and birth, and the first few weeks of this child's life. You are not there to take over. You are not there to do it for her. She is the one that's going to be doing the work. You're just going to be helping her with it. And I think it's keeping that understanding in your mind, and just taking it for granted that she's the main mover and shaker for this birth. She is. (Pamela, midwife)

Pamela speaks of her role as helper and facilitator. She does not manage the woman's pregnancy and birth; rather she is directed by the woman. And yet certainly midwifery clients come to midwives for their knowledge and skill, much of which is based in scientific evidence, as well as to be supported, mothered. The balance between being an expert resource and confidant, surrogate sister/mother and primary healthcare provider is complex. Page (2000) states that the midwifery relation is "both personal and professional, often being like a friendship with a purpose" (p. 8) This substantiates the sense of partnership that Pamela speaks of. James (1997), however, suggests a greater depth of engagement, an implication that regardless of the duration of the relationship, midwives have a profound and lasting effect on the lives of the women they care for. She says, "Women experience midwifery care, a form of care that may evoke familiar feelings such as those experienced with close friends or family members... the possibilities of friends, mothers, sisters, angels within the relation of being *with woman.*" (p. 145)

Sheila's account shows this dedication and commitment for women, even when there is no new life at the end of the midwifery encounter. This example of the care for a childbearing woman is forged out of painful and poignant circumstances.

> I had a young woman who came to me pregnant because I had helped her sister-in-law have a baby. She wasn't quite sure whether she wanted an abortion, to give this baby up, or what. At eighteen weeks she had an ultrasound. She hemmed and hawed about that. And the ultrasound wasn't very pretty. So I was paged by the radiologist saying this baby had got gross malformations and probably wouldn't live. So I phoned the perinatologist, who said, "Sheila, this baby has got severe cystic hydroma," which is a huge tumor on the side of the face, "And Turner's syndrome. And it's ninety-nine point nine percent likely this baby will die. The client can come in for an early induction."
>
> But I went around to the girl's house, and I said, "I need to talk you wherever you feel comfortable." I said, "this is not very nice news and I just want you to know that." I held her hand, and I said, "This is what is wrong with your baby: the baby has a nasty tumour full of water, and the baby has probably got Turners Syndrome, and may not survive." I spent two hours with her. Lots of tears; everybody cried.
>
> We went together to see the perinatologist. I cancelled my appointments so I could go with her, to hear what he said, because sometimes when the doctor says things, the women can't hear it. She did not choose to have an early induction. She chose to have an amniocentesis. She is a very bright girl, she hit

the internet and came back saying, "Sheila, Turner Syndrome children can survive. I don't want an early induction. I want to have the amniocentesis and leave things alone."

She came to see me at my office for a visit – I was monitoring her blood pressure regularly – and said, "Take the baby's heartbeat." I knew that the baby had been growing. She was about twenty-eight weeks pregnant by this time. And I said, "I can't hear the baby's heart-beat. You need to get to the hospital." Of course the baby was dead. So she went for an induction.

When the baby was born it was grossly abnormal; very, grossly abnormal. But she wanted to see the baby. The nurse said, "She *can't* see the baby." But I said, "Well, we'll take a picture. Let's wait and see. If she wants to see this baby she has a right." I didn't want to do this. We both cried. She had to have lots of drugs because the baby was breech and so I was concerned that if she saw the baby right there and then she would hallucinate. So I said, "Let's have a good sleep, get the drugs out of your system, and we'll wrap the baby up and you can have the baby in the morning."

In the morning I said to her, "The baby is quite abnormal. Okay? So I'll show you the foot first," because the foot was fine. And I said "Then I'll show you the hand, and if you feel good about that, then we'll show you the rest." Somehow or other it was wonderful. She saw the foot, she touched the foot; she touched the hand. And she said "I want to see the face now." And for some reason it looked okay. The eyes were not what you like to see, but it was okay. And the lips were okay; she touched the lips. She had a special cloth to wrap the baby up,

and I took pictures of the baby wrapped in this cloth for her. We spent a long time together. One of the nicest things about midwifery is that I can cancel my day. You can do that for these women. You need time.

When I had finished care with this young woman, we said good-bye, and I held her, and she cried. In the end she gave me this picture that she drew of her baby and of a normal baby. They were superimposed on each other in a surrealistic way. And she wrote some lovely words to me. She said, "Because of you, Sheila, I'm going to be a midwife. I'm going back east." She's going to Ryerson next year; she got in. She did this all because she said she appreciated women being with women for women. So this is midwifery. It's a total experience, a very, very earthy, gutsy, wonderful experience. And nobody... doctors can't tell you this, hospitals can't tell you this, but women can tell you these real stories. (Sheila, midwife)

This is a story of patience, witness and response. The midwife is truly *with* this young woman through her experience of carrying life and then death in her body, waiting over the span of weeks for a sense of meaning to be born from this difficult experience. She bears active witness to the woman's evolving attachment to and relinquishment of an anomalous fetus. Her active witnessing is to be patiently present and available; ready to respond when the other, with whom she waits, addresses her. In actively witnessing she also remembers and holds the truth of this woman's experience within herself so that the woman does not stand in it alone either in the present or a future time. Levinas (2000, p. 198) says, "Bearing witness is not expressed in or by dialogue but in the formula *here I*

am." It is the ethical opening of the self to the other that willingly awaits to be filled by responsibility in the other's need.

Sheila witnesses what might be understood as this mother's 'preservative love' (Kittay, 1999) for her dying fetus, easing her transition to acceptance of her loss. Although while carrying the child the young mother has not encountered her child face-to-face, her desire to keep the child, as it grows within her, also grows. Kittay (1999) speaks of preservative love as the most fundamental of maternal requirements, heightened when a child is made more vulnerable by disability. As the mother in this story seeks to hold onto and protect her disabled fetus, Sheila, embraces the mother with her patient, watchful care. Sheila suggests that this standing with and opening to women in the wonder, totality, and 'gutsiness' of their experience is the meaning of midwifery. It is witnessing women's transformation in becoming mothers, however that might occur, and in this case was helping one woman to bind up the raw, ragged ends and conserve her mothering to give to other women.

'Angels' and 'Friends'[2]

Despite the empowered trust that midwifery clients develop in themselves and the confidence that their midwives have in the process of birth, occasionally situations of high risk occur. Most of the midwives in this study told anecdotes of such situations where they needed to act quickly to forestall injury to the mother or baby. Although much of midwifery care is waiting and watching (James, 1997), midwives must be prepared with the necessary knowledge and skills to respond immediately in non-medical contexts. Hilary has practiced midwifery for many years and several of the stories she told came

[2] This thematic title is borrowed from the previous quote from James (1997, p.145).

from the time before she had hospital privileges as a registered midwife. Most of the births she attended before midwifery regulation were at home. This story tells of two home births and an emergency situation.

> Sometimes you feel like maybe you have angels on your shoulders. You would just be tucked up in the bed one-day reading about something, and it shows up the next day. This is exactly what happened to me with a shoulder dystocia[3].
>
> The sister of a pregnant client of mine was in labour in the hospital and just got really annoyed and upset with all that was going on there. I guess she was not communicating well with the nurse. So she and her doula, who was also a friend of mine, phoned me to see what to do. And I said, "Why don't you just take a break. Why don't you just ask the nurse to listen to the baby, then go outside and wander around for a bit? It's a lovely day." Well, they did that, except that they came to my house. They walked in my door, and her membranes ruptured and then an hour and a half later she had the baby at my house. Her sister, my client, arrived to be with her for the birth, and suddenly *her* waters broke. They just spontaneously ruptured!
>
> So she went home, and I got maybe a couple of hours sleep before I went out there. And I was sitting on her back porch having a cup of tea – she was in good labour – and I just suddenly started thinking about episiotomy. I started running it through my mind. And this birth was the shoulder dystocia. When the baby's head was born I just instantly knew. And so I got my partner to phone the

[3] Shoulder dystocia: impaction of the baby's anterior (upper most) shoulder behind the mother's pubic bone. Disimpaction is effected by various maneuvers implemented by the accoucheur to rotate the baby. This is an emergency situation and can result in the baby's injury or death.

ambulance right away. And I had to do an episiotomy. I had to do one; I just couldn't get my hands in. And so I did that and I finally got the baby out just as the ambulance pulled up. It was seven minutes. We called them as soon as I saw the shoulder dystocia; because of course they time it. It was seven minutes. This was an eleven pound six ounce baby. And she was only nineteen inches long. So she was just a little chubber. And I remember during that birth, Varney's [a midwifery text] page on shoulder dystocia was running in my head like it was on a TV screen. '...now do this, and if the baby is not delivered, do this, and if the baby is not delivered, now do this.' I had to go through all of the maneuvers. I had to corkscrew the baby twice. She was just so fat. I will always remember that, it was just like I knew intuitively to get myself prepared. And so I wasn't scared until afterwards. Fortunately, the baby was good. (Hilary, midwife)

It is extraordinary, from the point of view of mainstream, conventional healthcare, to envisage the first pregnant, labouring woman, accompanied by her doula, leaving the hospital to arrive at the door of an acquaintance and subsequently, casually, to give birth in her home. And yet this is undoubtedly the way in which women have birthed for millennia – in the comfort and company of their women-community. Hilary was not even this woman's primary caregiver; however, she was known to have knowledge and skill and an open door for childbearing women. Here too, as with the nurses, these women found hospitality. Later, as the second woman (the sister of the first) labours, Hilary sits contemplatively on her porch sipping tea. Again the image shows us childbearing interwoven into the homey, relational fabric of these women's lives. However, Hilary's relaxation is not irresponsible dithering. She reflects on the exigencies of difficult births,

having spontaneously chosen to remind herself of how to do an episiotomy, after, the night before, reviewing the management of shoulder dystocia. This intermingling of casual comfort, neighbourliness, and obstetrical clinical knowledge is an odd juxtaposition given the arcane inaccessibility with which medical knowledge is often regarded.

Davis-Floyd and Davis (1997) speak of the 'postmodern midwife' as a caregiver who moves with fluidity between the biomedical and holistic paradigms, adapting what best serves the woman and situation from both. A part of this fluidity is attention to the ways in which intuition directs the use of their knowledge. The authors study of intuition in midwifery shows how midwives rely on its "trustworthiness" (p.339) in their practice. This intuition is born out of midwives' connection with the women they care for that is physical, emotional, intellectual and psychic. However, it also results from their connection to themselves, their inner thoughts and feelings (p.324). Hilary saw the client throughout her pregnancy and so probably knew her quite well. Perhaps when palpating the woman's abdomen, it was experience resonating in her own body, received through her hands, that told her something noteworthy in this mother-baby chiasm. Did such embodied knowledge set her intuition to work, calling her to review shoulder dystocia and episiotomy? Intuition may be the angel perched on the shoulder of the midwife.

Two Worlds

The words of the participants bring different worlds into being. The midwife who stood attentively by while a dancing woman birthed her baby into her own hands seems like a far distant planet from the nurse who gave constant support at the bedside of a

woman with a forceps delivery, third degree tear, and baby in the special care nursery. The flexible, portable relationship between midwives and their clients, that allows them to interact in various settings over the full course of pregnancy, birth and the postpartum, is very different from the brief, intense, often less verbal interactions of nurses and their patients in the hospital setting. Yet, when midwifery clients, come to the hospital by choice or necessity these caregivers often meet and interact in close proximity with each other and women for whom they share the responsibility of care. What is it like to bring these two different worlds together? Are the differences shown in their experiences inherent in their professional cultures, knowledge, and philosophies? As has been shown, both nurses and midwives demonstrate deep commitment to childbearing women and families. How do the women figure in their interactions with one another? What do their ways of being with and caring for childbearing women say about the meanings of birth they hold? And if these meanings differ, how are their experiences of interaction affected by the difference?

In the following chapters I explore the dimensions of relation between nurses and midwives in the hospital setting, as shown in their experiences of interaction. Through their accounts I begin to trace a thread of ethical collegiality, evident many times in the space left open by its elision. Women and babies are present throughout the participants' accounts and are the site where encounters with difference are played out.

CHAPTER FIVE

DIMENSIONS OF INTERACTION AND CONFLICT:

EXPECTING, ASSUMING MISUNDERSTANDING

Medical intervention, in the broad sense, is based predominantly in a specific scientific, taxonomically-based and objective epistemology. It is the purpose of hospitals, directed at the alleviation of illness, pain and pathology, and the preservation of life. Hospitals are 'home' to medical intervention; it has its primary 'implacement' in them (Casey, 1993). This scientific, clinical knowledge has shaped hospitals both architecturally for observation, control and efficiency (Foucault, 1994) and in accommodation of those who 'dwell' in them; that is, those experts whose professional identities and capacities are comfortably enacted there (Heidegger, 1993). In addition, although patients do not generally dwell in the hospital with the comfort or at-home-ness that doctors, nurses, and other mainstream healthcare providers do, they too are designated to be there, within the understandings of medical epistemology, as in need of expertly given medical intervention and surveillance. To a degree, which is more or less temporally conscribed, the 'place' of the hospital, and the identities of the professionals and patients within it, are mutually conferred. "Where something or someone is, far from being a causal qualification, is one of its determining properties" (Casey, 1993, p. 307).

Hospital-based nurses play a key role in carrying out this surveillance and interventive purpose in thought and action in ways that support the hospital as place through their use of scientific knowledge and organizational habit. However, caring and nurturing are equally a part of nurses' identity and the ways in which they 'dwell' in the

hospital as place. As Heidegger (1993) explains in his examination of the meaning of the verbs, to 'build' and to 'dwell,' these words also encompass or imply the meaning, to cherish, protect and care for; in other words, to nurture. The word, *hospital*, is derived from the same root as *host, hostel, hotel*; all words that speak of *hospitality*, the act of receiving and offering sustenance and good will to friends and strangers alike (Simpson, et al., 1989). As illustrated by nurses' morally motivated and caring relationships with childbearing women in Chapter Four, the abstract, scientific, analytic thinking that assesses the need for, and supports, medical intervention is balanced and reflected in the nurturing actions of nursing; brought into holistic understanding through inherent, embodied knowledge in response to the individual (Bergum, 1994, 2003; Cameron, 1998).

Community-based midwives, too, demonstrate this integration of abstract, scientific knowledge and knowledge of the individual woman, regardless of the specific context of care, and less exclusively dictated by a specific epistemological paradigm. For them, in the hospital setting, nurturing acts focused on the individual woman may be their primary concern, depending on the circumstances of the birth event. When any situation other than a relatively straightforward vaginal delivery is anticipated, consultation is sought and responsibility for formal care may be transferred to a physician specialist with the midwife continuing to offer supportive care (College of Midwives of British Columbia, 1997a, 1997b). In this regard, within the hospital setting, midwives attention to the carrying out of medically interventive tasks and approaches may be of less importance in exercising their skills. In addition, because midwives are not employed by hospitals, they do not have the same taken-for-granted duty to support the ethos of the

hospital as place that nurses have. Nevertheless, the hospital ethos with its focus on mitigation of the pathological, as well as many other institutional qualities inherent in the hospital environment, shapes the circumstances of interaction between nurses and midwives in the hospital setting.

As an institution, the hospital is the concrete manifestation of an entire apparatus that expresses the medical-scientific episteme, its discourses, regulatory mechanisms, and philosophy (Foucault, 1981). Edified into its architectural plan are theories of asepsis, clinical observation, environmental control, normalization, and hierarchical expertise. This is the setting for interaction and negotiation of roles and responsibilities between the nurse midwife and woman.

The birthing room in which a nurse and midwife might meet, regardless of the warm, calming colours, homey bed cover and curtains in which it may be decorated, is unmistakably a hospital room. It is finished in durable, easily disinfected surfaces; at least one wall is lined with outlets for suction and oxygen; and discrete, strategically placed cupboards and shelves hold sterile, packaged, medical supplies. Parked in one corner is a cart supporting a radiant warmer for the newborn, oxygen tanks and resuscitation equipment. Also placed somewhere out of the way is a wheeled, stainless steel table on which a sterile "delivery kit" can be set-up with scissors, clamps, gauze pads, syringes and needles, among other items. Only the head of the birthing bed is against one wall in order to provide caregivers with easy access from three sides to the woman who occupies it. Privacy may be afforded by a curtain drawn across part of the room or a door closing the room off from the busy corridor and nursing station traffic. The context of interaction between nurses and midwives is also affected by the hospital schedule with its cycle of

nursing shifts, physician rounds, and visiting hours. Then there are the events of an individual woman's labour and the potential for necessary medical intervention, leading to the subsequent readying and operation of accessible instruments and equipment. Another institutional factor, one over which nurses and midwives must negotiate, is the responsibility for documentation; and the ongoing need to keep those responsible for the smooth running of the unit informed of the progress of mother and baby. In addition, in the minds of some nurses and midwives, there may be the dark backdrop of uncertainty regarding medico-legal responsibility for care.

It is stating the obvious to say that childbearing is in no way an illness, although it is a deeply embodied experience involving enormous exertion and the pain of labour, as well as relatively impressive amounts of blood and body fluids. As has been shown, it is an event that frequently takes place in a natural and uncomplicated manner in people's homes or other non-institutional settings. Nevertheless, the normal human event of childbirth, when it takes place in the hospital setting, is subject to the assumptions that permeate the hospital as a place; that is, assumptions that support a type of vigilance holding the worst-case-scenario as the standard of preparedness (Murphy-Lawless, 1998). In part, this is experiential wisdom at work given that sudden and dire situations, such as a massive, unanticipated postpartum hemorrhage, or a baby born with a congenital diaphragmatic hernia, do on occasion occur. Also, for some women whose pregnancies are endangered by illness or other complicating factors birth with a reasonable outcome may be impossible except through interventions available only in the hospital. This level of available technological mediation and control is also, however, a reflection of a scientific paradigm that views women as weak and childbirth as risk-prone (Gadow,

1994; Murphy-Lawless, 1998). For all hospital births, in order that the same vigilance for the dangerous and unexpected is employed in all cases, standards and guidelines for prudent professional practice as well as hospital policies and protocols are established and enforced. These strict conventions also play a part in ensuring that the interface between nurses and midwives occurs.

Policies, guidelines and standards of practice universal to perinatal care in British Columbia include the requirement that there are at least two people at every birth, the primary caregiver and an additional person for the baby, who have current training and certification in cardiopulmonary resuscitation (CPR) and neonatal resuscitation. If neonatal compromise is anticipated, three people including two trained individuals to care for the infant alone should be present (British Columbia Reproductive Care Program, 2002; College of Midwives of British Columbia, 2004). These individuals who are present at birth for the baby may be registered nurses, physicians, midwives, emergency medical technicians, or others. At the deliveries of physicians' patients in the hospital setting there are generally two registered nurses in addition to the physician: the nurse responsible for the labouring woman who assists the physician, and the 'baby nurse.' Likewise, in British Columbia, when midwives' clients birth in the hospital at least one registered nurse is usually present for the baby. The occasional exception is when a second midwife or conditional midwifery registrant[4] is present.

[4] Midwives educated outside of Canada, or those wishing registration through the 'grand-mothering in' process, must meet three prior learning assessment criteria: midwifery education, English language fluency, and clinical experience. If an applicant for registration does not meet the all of clinical experience requirements, but has been the principle midwife at a specified minimum number of births, they may register as a Conditional Registrant and complete the further required births as principle midwife under the supervision of a General Registrant (fully qualified registered midwife) (College of Midwives of British Columbia, 2003).

Aside from requirements at the time of delivery, the degree of interaction between nurses and midwives, or nurses and physicians for that matter, in the care of childbearing women and their babies may vary depending partly on the individual hospital's policies, the client's/patient's wishes, the circumstances of the labour and birth, the primary caregiver's desire or need for assistance, the patient-load on the unit, and the individual personalities involved. For nurses and physicians interprofessional teamwork is a taken-for-granted aspect of providing healthcare in the hospital milieu. Although interactions may be more or less comfortable, the players, even if not well known to one another, can safely make assumptions regarding their prescribed roles, responsibilities and expectations of one another. There is an unspoken commitment and sense of duty to work together. The participants in this study indicated that, in many cases, this same sense of commitment to teamwork and shared responsibility does not come easily between nurses and midwives. Clarification and negotiation of expectations are often not well communicated and a sense of confusion regarding roles and responsibilities seems to be common. Participants' accounts elucidate the nature of this experience of interaction.

Multiprofessional Solitudes

The anecdotes in this chapter describe interactions between nurses and midwives related to the care of midwives' clients in the hospital setting. They point to expectations and assumptions on the part of both groups of professionals, for themselves and one another, which can lead to conflict; experiences of misunderstanding, anger, resentment and indignation. How are the nature and comportment of both professions played out in proximity to one another? How do expectations, assumptions and judgments shape

midwives' and nurses' experiences of interaction? How do the hospital context and social structures contribute to taken-for-granted ways of being that might confirm presumptions about one another and the care of childbearing women? The experiences shown here provide insight into these questions.

It was pure coincidence that a nurse and midwife who had worked together both volunteered to take part in this study and that they each chose to speak about the same experience of interaction. Their telling of the same event reveals much about the professional life-world of each and how differences between them reinforce perceived divisions of power and authority. These accounts, the themes of which are echoed and intensified in the participant anecdotes that follow, provide an appropriate overture to the rest of the chapter.

Vivian, a perinatal nurse, was assigned to Deanna, a midwife, and her client, who came into the hospital at about midnight. The midwife had been supporting this woman in labour at home throughout the day before and was almost twenty-four hours without sleep. Early in the morning the midwife's client desired and received an epidural. Best practice guidelines and most hospitals require that a woman with an epidural in labour have one-on-one care provided by a caregiver experienced with the necessary technology and patient monitoring. In this case, the midwife chose to turn responsibility for care related to the epidural over to the nurse. Once her client was settled and comfortable, the midwife, Deanna went to check on another client and her baby who were on the postpartum ward, leaving Vivian, the nurse, to care for the labouring woman until she returned. Both the nurse and midwife describe this experience of interaction. Vivian begins.

Let me tell you about a situation I had with a midwife I hadn't met before. I had a case with her and she was initially very pleasant. This was a multip [the patient was a multipara] and she was just getting an epidural at eight centimeters. The midwife told me that she was going to make rounds and look at one of her babies while I organized the epidural and got all those things sorted out. So she told me she would be back in twenty minutes, or something like that, and left. She did give me a specific time frame as to when she would be back.

So then, of course, as soon as she left, her patient started feeling pushy. And, you know, out of respect for the midwife I held off checking the patient [assessing cervical dilation by vaginal exam]. And then the twenty minutes was up and I thought, well, the midwife is going to be back any minute, so I didn't want to page her to come. So anyhow, time went by and the patient was feeling really pushy. By this time the midwife had been gone about forty-five minutes and I thought, okay, I'm just going to slip my fingers in here and just see where we're at. And just as I was finishing the exam, of course the midwife came in.

And, you know, I could tell right away that she was annoyed with me for examining her patient. And so she pulls me into the bathroom and says, "Why did you examine my patient? I like to do that myself. Why didn't you page me?" So I thought, okay, all right, I need to apologize. And I said, "I'm sorry. I thought you would be back, and then she was getting more and more pushy." But from then on, it was like, "Could you just do the catheter bag? Could you do this? Could you do that?" and "Oh, I didn't notice what time she delivered, so could you fill in all these bits and pieces on the forms?" And she flounced off! And I did all the

cleaning up and everything. And I was furious because it was an obvious power-over situation. (Vivian, perinatal nurse)

Left alone to care for the midwife's client it was reasonable for Vivian to provide that care in the ways in which she would for any labouring woman. However, it seems that the midwife's assumptions regarding what she was there to do were different. Perhaps she only wanted the nurse to monitor the epidural infusion and take vital signs on her client as required by this intervention. Even so, the nurse's impulse to check the dilation of the woman's cervix once she felt an urge to push was sensible and routine from the nurse's perspective. The partogram (labour record) calls for the time of full dilation to be recorded. More importantly, if it is known that a woman's cervix is completely opened and out of the way of the presenting fetal part, then the woman can safely give in to her powerful urge to push without injury to her cervix. If she were to push against a partially dilated cervix the cervical tissue would become bruised and swollen, impeding the descent and expulsion of the baby. Although she waited in deference to the midwife's relationship with her client and her position as primary caregiver, the nurse eventually chose to assess the woman. The urge to push is incredibly powerful and difficult to resist. If her cervix was fully dilated then this woman could safely do what her body was urgently telling her; to actively push toward birthing her baby.

The nurse's description of the midwife's reaction suggests that her autonomous action created dramatic shift in the quality of their relating. Was she being punished for stepping outside of the midwife's expectations? She was not only reprimanded, but felt that her status was somehow altered in the midwife's view as shown by her perfunctory

demands that the nurse should do the scut work. Vivian suggests that her experience in this was one of oppression.

The following is the midwife's, Deanna's, account of this event.

Awhile ago I was at a birth. I had been with her [the client] at home, and then we came into the hospital about midnight. And she finally had a normal birth just after seven a.m. or something. I had not had a break. I hadn't had anything to eat. So I had been up all day the day before and this was six or seven in the morning. And I will have to take ownership for that, because you know, sometimes it's not friendly there, and you get snide remarks if you say you want to take a break. However, I did actually take time to go see another client on the postpartum ward.

So at one point when the [labouring] woman was comfortable with an epidural, I said to the nurse who was in the room that I was just going to go to see this other gal, but, "Call me..." And I thought the nurse understood, '...If you want to do a VE[5].' Like, I was only going to be, you know, half-an-hour. Anyhow, I come back and the nurse is checking the woman. The reason I wanted to check her myself is that she had had a previous caesarean. And based on the notes, I think she had been pushing on an undilated cervix for hours before going to the OR. So this is what I wanted to avoid. I wanted to make sure that she was really fully dilated before she started to push. I didn't want her to go through what she had the time before. So anyhow, I get back into the room, this nurse is checking her, and looks really guilty. So I'm just kind of, 'What are you doing!?' I took her aside and I just said, "Well, when I am here I like to do my own checks,

[5] Vaginal Exam (VE): digital examination of the uterine cervix and the presenting fetal part via the vagina.

and I said to you, 'Call me!'" Meanwhile I'm very tired. But we had a reasonable birth. (Deanna, midwife)

Deanna demonstrated intense commitment toward her client in staying at the woman's side for many hours during her labour. This attentiveness is understandable given that this woman was attempting to have a vaginal birth after a previous caesarean section. In this the midwife says that she sacrificed her own needs for adequate rest and food. Although, once at the hospital, she suggests that she refrained from taking a break in order to avoid unpleasantness with the nurses. Nevertheless, she left nurse Vivian in the room with the labouring woman while she went to visit another client. As she indicates in this story, the midwife wanted to have careful oversight of the progress of her client's labour. Her voice in relating this experience demonstrated annoyance and indignation at the nurse's action in examining the woman, suggests that it was viewed as unruly and intrusive. Is her comment that the nurse looked guilty a reflection of a shared understanding that some boundary had been transgressed? Her reaction may have been due to fatigue. However, this situation demonstrates what seems to be the midwife's expectation that she would oversee the woman's care and that the nurse would assist as she directed. What in this situation created the misunderstanding between the nurse and midwife? Why was there not an easier, more equitable collaboration between them?

The nurse's and midwife's descriptions of this interaction reveal much about the focus of each in caring for the same woman. Both showed concerned for the woman's well-being, safety and comfort but their words unravel details that indicate somewhat differing significances in the dimensions of this birth event. The nurse begins her account with the procedure, the epidural, as the initial focal point of interaction. She speaks of

coming together with this midwife and her client to manage and monitor this intervention. In essence, she was called in to enact a technical skill. This is not to say that she had no responsibility toward the woman; she clearly did. However, she takes on a role in this situation as ancillary and skill- or procedure-oriented. As the nurse's anecdote unfolds, this understanding appears to have been supported by the midwife's words and behaviour. However, when care is temporarily turned over to the nurse she falls into the comportment she is accustomed to in her place of work (Heidegger, 1962, p. 23,162) and freely brings to bear her practices and ways of being as a perinatal nurse, which far exceed this technical role. The scope within which the nurse frames this interaction reflects the circumscriptions of time, place and relation for her as a hospital-based perinatal nurse. As described in the introduction to this chapter, a nurse such as herself has contact with midwives and their clients limited to specific conditions and needs that she may be deemed to have a role in fulfilling, but over which she has little control. This contact is always at a time, for a duration, and in a place dictated by the midwife and her client, the consultant, and/or circumstance, and presents unpredictable opportunity for establishing trusting relationships. Although the hospital is her 'home,' its ways and social structure inhibit the likelihood of giving primacy to relation over procedure and technical skill in these interactions.

The midwife begins her account quite differently from the nurse by speaking of the event as a whole, "a birth." This perspective speaks of her purview as the primary caregiver. In particular, in this role, she would have had a relationship with the client over a relatively extended period of time and would have focused with her client on the final outcome, the birth of the baby and its import for the mother-baby-family relation. Use of

the hospital space and the interventions available in it was not central for the midwife, although they offered safety, client comfort in the form of an epidural, and convenience. Each of the actions taken to facilitate the labour and birth were important; however, as a midwife she would have carried before her the larger view of this pregnancy and birth in the context of her client's life and history. From this perspective, like the interventions, interaction with the nurse might have seemed relatively unimportant. She refers to her simply as "the nurse who was in the room", another entity sharing the same space. Although the midwife's initial words about the nurse's role frame her as necessary for the midwife's purpose, she is spoken of more as a useful instrument than an integral team member for this birth and is largely incidental to what was going on between herself and her client. This semi-objectification of the nurse is illustrated by the fact that it was only when she acted unexpectedly from the midwife's point of view that she received particular notice – and reprimand. At this point the fairly smooth, if indifferent, functioning of their work together broke down. The midwife altered her way of dealing with the situation, choosing to pay attention to the nurse's actions and to specifically direct and limit them for the remainder of their interaction, apparently opting to assert her authority rather than seek further understanding and resolution.

Juxtaposing these descriptions suggests marked differences in how each of these caregiving professionals was facilitated to participate in the labour and birth according to their self- and role-understanding. The midwife seized jurisdiction and authority over almost everything related to the labour and birth in order to provide the best individualized care for her client, and was surprised and disturbed by the nurse's unexpected 'interference.' The nurse, too, was surprised and disturbed at being

admonished for acting autonomously within her scope of knowledge and practice. Both were apparently hindered by their assumptions, lack of communication, and non-consensus regarding the kind of relationship they could have had in providing care together. The reality of a collegial, *interprofessional* relationship, a team whose members respectfully confer and whose roles comfortably blend, did not seem to be a possibility (Schober & McKay, 2004). They each stood alone within the self-protective understanding of their different knowledges, roles, professional identities, and world-views. They provided *multiprofessional* care to the birthing woman, sharing the same space, but isolated from one another and the possibility of synergy that their collaboration might have created (Schober & McKay, 2004).

Midwives' Experiences: Interacting with Nurses

The midwife-participants in this study described working with nurses at the respective hospitals where they hold privileges as unpredictable in that they could never be certain which nurses would be working at the time of a client's admission. Most of them indicated that a few nurses were wonderful to work with and that they looked forward to their company and assistance. There were also nurses who they sought to keep away from their clients and to have little contact with themselves because of their unpleasantness. The following anecdotes and accounts show how many nurses, though generally competent and available at specified times, demonstrated reluctance to engage with the midwives and their clients and a bewildering passivity when they did. Avoidance, resentment and vindictiveness, as well as the misunderstanding that results

from poor communication and unacknowledged assumptions about one another characterize their interactions.

Second Pair of Hands or Handmaiden?

Judith is a midwife most of whose hospital deliveries are at a large, busy, urban hospital where she frequently interacts with perinatal nurses. Nurses who work in relatively busy, high volume tertiary centres often need to focus on the most efficient ways of getting women through labour and delivery safely and happily. This makes the protocol, routine and habit of the institutional setting an easy way of working and one with which they are comfortable. These nurses are experienced and highly skilled, capable of acting quickly and appropriately in medically emergent situations. However, most of their work as labour and delivery nurses is related to helping women and assisting physicians to effect relatively satisfying, routine and uneventful hospital births. These nurses, as professionals, only encounter midwives with their clients in the hospital setting and may formulate their impressions of the community-based midwifery role on this contact. Judith provides insight into the context of these interactions and the impressions they engender.

> I think the most common comments that we hear from the nurses are, "What do you guys do that we don't do? What do you do differently?" And, of course, the nurses in our hospital come in for the delivery; they don't really spend much time in the labour room with us; they don't really see that much of what we do. And even then, they wait for us to call them in. So, they come in at the time of delivery basically to be our second pair of hands, just the same as when we call a second midwife for a homebirth. It's exactly the same role. They're basically just there

> for the delivery of the baby and the placenta and then they're gone. My expectation of the nurse, and I know this varies a little bit from community to community, but in this community it's pretty clear that their role would be for the baby. And, of course, to help out with the mom if we need anything, like if there was a hemorrhage. In that case I would be saying, "Give the oxytocin, start the IV, blah, blah, blah." But they're there mainly for the baby. They come in and check the warmer and the resuscitation equipment and stuff. In the case of a resuscitation they would start, and if they couldn't bring the baby around, then I would expect them to call me to do it. (Judith, midwife)

Although Judith maintains that the nurses do not see much of the midwives' practice it seems that they see enough to gain the impression that midwives are, for the most part, doing the same work and using the same skills and knowledge that they themselves use. This makes their questions, "What do you guys do that we don't do? What do you do differently?" understandable. These questions may also imply, 'Why do community-based midwives have privileges and status that we ourselves are not granted? Why is it that midwives can autonomously manage births and experienced perinatal nurses cannot?' But are their assumptions regarding the similarities between how midwives care for their clients and their own work accurate? Viewed in brief glimpses through a perinatal nursing lens midwifery work may look the same as what nurses do themselves; however, the philosophical basis for this work, how the event of birth is understood, and midwives' relationships with the women they care for may be different in significant ways.

The midwife's description suggests that she would speak to a nurse working with her in a mildly imperative and authoritative manner, more as a physician might, and implying the same directorial role on her part; less in the consultative manner of a nurse coworker. Nevertheless, her words indicate that she also takes for granted nurses' expertise and ability to act appropriately and autonomously in the case of an infant resuscitation. She depends on them to be knowledgeable and skilled in this. The midwife also states that her expectation of the nurse's role is that of a "second midwife" who attends a home birth; though not the primary caregiver, and someone who would to defer to the primary midwife's knowledge of the client, nevertheless, a person who is comfortable with the context and capable of working harmoniously within the situation; a true colleague. Does this imply that the nurse is someone of equal status to the midwife in this regard? Inherent in this expectation might be the assumption that nurses approach the concrete aspects of birth in the same way as midwives, that the actions of a midwife, in most cases, will be understood as appropriate by the nurse and vice versa. That is, although they do not share the same professional identities, they are, or should be, alike enough to share the same common sense about what needs to be done in labour and birth situations. If this is so, then like the nurses, the midwife is overlooking in her assumptions philosophical differences that may manifest in very different perceptions of risk, the need for intervention, and the primacy of the mother-baby relation.

Regardless of the accuracy of their assumptions and the possible implications of their similarities, the nurses' questions indicate that they puzzle over and perhaps are unsettled by a perceived differentiation in status between themselves and midwives, as well as midwives' somewhat contradictory expectations of them. Might the midwife's

stated expectation – a "second pair of hands" – be understood by the nurses as uncomfortably close to 'handmaiden;' an image, or perhaps a caricature, of the nurse with a long history that has served to keep nurses oppressed and disrespected as much as it has accurately defined them as helpers and caregivers (Boutilier, 1994; Bridges, 1990; Coburn, 1988; Kitson, 1997)? If so, midwives and their expectations may be felt by nurses to be devaluing of their identity and role.

Avoiding

Judith, the midwife, goes on to express her awareness of nurses' reluctance to take on the midwife-designated role or even to interact with midwives.

> I think I make them feel welcome to come in and to spend as much time as they want with us, and certainly I introduce them when I first come in with a client. But they're reluctant to come in and then just can't seem to get out of the room fast enough.

What do nurses experience that causes them to wait to interact with midwives and their clients until they must, and after completing requisite tasks, to leave the room as quickly as possible? Is it the demands and busyness of the unit that call them, or is it avoidance caused by either antipathy or uncertainty as to how they should respond and behave? They may sense that they are not really needed, not truly welcomed; or are, themselves, unwilling to be welcoming of the midwife and her client in their familiar space.

The verb, *to avoid*, comes from the Old French meaning to empty out, to quit, get rid of, or banish. In other words, it is to make void, empty, to invalidate something, as well as to keep away from something (Simpson, et al., 1989). Some nurses seem to 'cast midwives out' by removing themselves from any proximity with them. In doing this, they

'empty' of midwives the personal space in which they allow social interaction or camaraderie to take place. Bauman (1993), citing Levi-Strauss, speaks of how primitive societies deal with strangers, outsiders, and enemies by an "*anthropophagic* strategy".

> "[T]hey eat up, devour and digest (*biologically* incorporate and assimilate) such strangers as master powerful, mysterious forces, perhaps hoping in this way to avail themselves of those forces, absorb them, make them their own." (p. 163)

Whereas, Bauman says, the strategy that modern societies use is "*anthropoemic*", from the Greek 'to vomit'; that is, "We throw the carriers of danger up – and away from where the orderly life is conducted; we keep them off society's bounds – either in exile or guarded in enclaves..." (p. 163). For many nurses, community-based midwives are strangers, and perhaps even dangerous in that they may be seen to threaten the role of nurses or the comfortable conduct of work within the hospital milieu. Could nurses learn from midwives, and midwives from nurses? This would mean acknowledging the power of one another's insight and experience, seeking to absorb or learn from it; to avidly 'eat up' what the strangers have to offer. Is their avoidance an attempt to guard their own knowledge so that the other will not consume it? Or might the taste of the other's knowledge show their own as less palatable? Instead, contact with midwives and their clients seems to be eschewed by nurses, rejected, thrown-up as distasteful and different. Nurses' avoidance invalidates what midwives bring to their sphere. They void it.

Painful and Punishing

The avoidance and resistance of some nurses seems to have the desired alienating effect for the Judith. Her anger and frustration are evident in the following comments.

So if you get a nurse that hasn't done that many cases with midwives, or avoids working with us, or whatever, she comes into the room and says, "What do you want me to do?" Meanwhile, we're in the middle of the head crowning and stuff. Now we used to just say, "Well, just do exactly what you would do if this was a physician case." But they just go *nuts*. You know? And so now we have to sort of 'parent' them. We talk to the nurses and say, "I want you to listen to the fetal heart. I want you to listen at least every five minutes. I want you to chart it in the usual place." Like, it's just every single step of the way. It takes a lot of energy; a *lot* of energy. And after the baby, "Can you please help me dry the baby off here? Can you make sure the baby has a good airway? Can you give the oxytocin? Can you...?" Like, it's just a *pain*! (Judith, midwife)

This midwife says that she and other midwives initially attempted to frame their expectations of nurses in terms that they assumed nurses would feel familiar with and could incorporate: "just do exactly what you would do if this was a physician case." However, clearly nurses experience differences between work with physicians and with midwives. What in the equating of these situations and expectations is the source of their anger, makes them "go *nuts*"? And why are some nurses so passive when called into the room to assist? The disequilibrium created by interacting with a new, strange, uncertainly defined group of caregivers in a context that is normally predicable and familiar is grounds for fear and resentment. In their relationships with childbearing women perinatal nurses normally feel confident and in control; with midwives' clients they may feel uncertain or excluded. The nurses' earlier questions suggest that midwives are not only unquantifiable strangers, but also perceived in their role as perhaps too uncomfortably

similar to nurses themselves to be given deference and assistance like physicians. Midwives, women like themselves, utilize essentially the same skills and knowledge base, but demand and have taken on greater autonomous responsibility; something that nurses have not been successful in achieving. Acquiescing to midwives' authority, then, may be resented and felt by nurses to reinforce a perception of their inferior status in the institutional healthcare hierarchy, and in the eyes of childbearing women. For nurses, this would betray as false the assertion that a nurse is equivalent to a second midwife at a birth, regardless of whether or not the actual hands-on practices are the same.

The midwife does not speculate as to the reasons for some nurses' resentment and obstructive behaviour, but she is intensely aware of it. Is this behaviour passive-aggression, a 'work-to-rule' attitude? Might nurses, in mistrusting some midwives, fear the legal repercussions if something were to go wrong? Or is it genuine confusion as to what nurses understand their role to be? Their apparent indifference creates "pain" for the midwife. Pain: an unpleasant feeling, a trouble, a punishment (Simpson, et al., 1989). It is clearly troubling for this midwife and, in effect is punishment for any discomfort the nurses might feel. Is her 'parenting' tone a way of simply offering guidance or is it also condescension? How might nurses feel when spoken to in this way?

Lacking Rapport

The primacy of a woman-centred approach and the power and importance of the midwife-client relation are major tenets underpinning community-based midwifery practice (James, 1997). An understanding of the importance of these beliefs for midwifery may elude some nurses' comprehension; nevertheless, nurses are aware of and sensitive to the intensity of the relational bond between client and midwife. Many are so

struck by the relation that they perceive it as a barrier, an unfathomed influence that makes entering the room where a midwife's client is labouring like crossing into a foreign territory, one in which the nurse feels uncertain of her place and her alliances. Are nurses concerned that they will be seen as intruders on the midwife-client relationship, or do they feel excluded by it? In the passage below the midwife seems to suggest both.

> What they say, the nurses that I have talked to, they say they don't have a rapport with the woman. So they don't feel they can get in there. And we say, "Well, the second midwife that comes to a home birth doesn't have a rapport with the woman either. And how is it that she can fit in and why can she do it and you can't? It's the same role." Here is an example of how, when nurses are in the room, they just stand back and let you do entirely your own thing.
>
> So, here I am with this nurse in the room, whom I know; I've known her for twenty-five years. We used to work together when I nursed here, and I know her personally. So I'm with this woman, my client, and she's pushing, pushing, and the head's crowning and she goes and grabs my arm. The woman is grabbing my arm, right? And I love this nurse; but I'm thinking, if I were a physician she would have been here sort of gently prying the woman's hand off. And, of course, I couldn't let go of the baby's head because it would pop out. And so I basically, very firmly, had to say to my client, "Let go of my arm!" But I felt like, why did I have to do that? You know? Especially at that moment. It just doesn't make sense. (Judith, midwife)

The midwife is baffled and annoyed by her former co-worker's reluctance to enter into her client's birth process and to work together with her. Her description suggests that this nurse did not interact verbally, or even to come into proximity with and touch the birthing woman. Did this nurse perceive the woman to be different in some way from all of the other women that she provides care for? Understandably, in the midwife's view, it was the nurse's responsibility to be aware and involved in what was going on, and to respond appropriately to events. She implies that the nurse's inaction may have negatively affected the woman's birth experience because she was forced to speak sternly to her. Has past experience suggested to this nurse that midwives' clients do not want nurses to engage with them? Perhaps the nurse feels that to take action she must be given permission or a particular place in the circle that surrounds a baby's birth. How might lack of rapport with the midwife's client deprive this nurse of a sense of being-in-place?

The midwife suggests that rapport with the woman is not necessary in order to assist and to be included in the work surrounding a birth. And, certainly, nurses do assist one another at deliveries where the second nurse has not encountered the patient until coming into the room at the time of the second stage of labour. However, the women that nurses assist together have chosen care by physicians and nurses. In most cases they have opted for, or believe that they need, the conventional model of childbirth that assumes a strictly biomedical approach and the security, even desirability, of available medical intervention. In this regard, nurses are these women's chosen birth attendants and can assume that their presence is desired and trusted. This assumption does not hold when caring for midwifery clients, who have chosen perinatal care and a caregiver based in a different philosophical perspective. In addition, rapport with the labouring woman may

not be the only significant aspect of working with others to facilitate a birth. Rapport, comfort and familiarity with the other caregivers involved are just as significant, or possibly even more significant, in terms of creating a relaxed, efficient and focused environment in which the birth can take place.

Judith, the midwife speaking, made a choice for a role different from nursing or medicine in becoming a midwife. The professional identity she took on is conflated by nurses with assumptions about status and power differentials, greater autonomy, and perceived negative judgment of the medical model of birth within which nurses practice (Kornelsen, Dahinten & Carty, 2000). In this anecdote, where the nurse and midwife had worked together previously as nurses, there has been a change in their professional relation that is unresolved in terms of roles and responsibilities. Perhaps for the nurse there is a sense of estrangement or awkwardness with her former co-worker. The midwife is there in what was once their shared professional environment with a new identity and her own client, a woman who by her choice of a midwife as primary caregiver is in essence the object of their present difference. In this regard, the client represents the interrogation of the nurse's professional role and commitments. Although her paralysis in the situation is difficult to understand, what might the nurse's participation and intervention by touching the client have symbolized for her?

Maintaining Distance

As illustrated in the previous midwife accounts, nurses seem reluctant or inhibited by a complex and confused miasma discomfort and uncertainty when working with midwives. Another midwife, Val, offers further elucidation of how this is experienced by midwives and how it affects the care of their clients.

This is the case: I had that postpartum hemorrhage, and everything else, and so there was nothing charted at all for half an hour. Nothing! So I'm writing a late entry, and I said to the nurse who was in the caseroom with me, "I'm gong to leave a blank space here for your vital signs on the baby. How many did you do?" She said, "Oh I didn't do any." I guess the look on my face was just, 'Huh?' She said, "Well, Dr. [X] examined the baby. You can track her down if you want for the vital signs." And I said, "I'm sure she just listened to the heart and lungs. She didn't count anything and there was no temperature taken." I just kind of stared at her, dumbfounded, and so she walked away. I didn't say a word. I think the look on my face was kind of puzzlement and stunned at the same time. And I didn't take the nurse to task on it, I just let it go. But, that's not totally unusual and there is not just one nurse like that.

Later the nurse manager said to me, "Val, there is some confusion. I don't know what it is, but some of these nurses still don't know what they're supposed to do when they go in the caseroom with you." I said, "Okay, I hear that. I will have to do something about that." So this morning I sat down with the nurse clinician and said, "You need to go back to everybody on the ward. When I ask for somebody to come in, they are not just there as a wallflower, they have a role. And they don't need to give eye drops and vitamin K to my babies, but they do need to do vital signs. And they do have to hang around and do what I ask them to do if I need help; which is exactly what they would do for the physician. And chart it! Chart it! They'll leave and there is nothing on the chart!" (Val, midwife)

Both midwives, Judith and Val, see no difference between nurses' role at a physician managed delivery and their role at a midwife client's delivery, yet, both experience reluctance on the part of some nurses to become involved. Val, the midwife relating the anecdote above accepted the explanation that there was simply confusion, that the nurses working on this unit were not clear as to their responsibilities. However, this confusion seems to beg the questions: why do some nurses assume that their role is different when working with a midwife? If a nurse is there primarily as the 'baby nurse,' as policy and safety demand, should not actively going through the steps of assessment and intervention-as-necessary, including taking the baby's vital signs, be the same as when a baby is born into a physician's hands? Should not the nurse's attentiveness to the events in the room and willingness to share in work for the delivery and immediate postpartum also be the same? This apparent passiveness, as well as reluctance to chart regarding the aspects of care for which the nurse generally assumes responsibility, left the midwife perplexed and taken aback.

Although midwives and nurses may approach a situation of birth with somewhat different interpretations about what is going on and should receive the greatest focus, the attendance of both is warranted as each brings important aspects of care to the situation based in their own professional roles. When a nurse is assigned to a midwife's client, that client also becomes in a relevant way her patient. Therefore, she has responsibility for particular aspects of assessment and care, as well as the documentation for those things within her accountability as she typically would for any patient. Although she is working together with a midwife, her work is still nursing work and she bears the same professional commitment to perform it. To stand passively by, then, is a failure to act

according to her commitment and responsibility, a failure to do her job. In this light, the deliberate inaction that the nurse in this story demonstrated is odd. Did she deliberately refuse to participate? The midwife was willing to give this nurse the benefit of the doubt, as she apparently had others, by accepting uncertainty as the explanation. What might nurses be uncertain about, if they are performing routine nursing work?

In speaking with the nurse clinician that was to take her concerns and instructions to the unit nursing staff, the midwife referred to 'her babies,' giving specific direction as to what must be done and what could be left. Perhaps another midwife, with 'her own babies,' would have slightly different expectations. Even if a nurse is conscientiously carrying out her usual responsibilities as the 'baby nurse' how is she to know the particular requirements of each midwife? The only way to accommodate such individual expectations is for communication and dialogue to take place. However, nurses may be reluctant to inquire, especially if contact with the midwife and client is limited to the second and third stages of labour when the midwife is most intensely focused and preoccupied with the birth. As indicated in the earlier midwife anecdotes, having to give direction to the nurse at this time may be extremely frustrating. A nurse's reluctance to interact with the midwife earlier on in a client's labour only contributes to this potentially exasperating situation at the time of delivery. Yet, nurses' professional formation requires them to not only act in the best interests of patients, but also to promote a collegial and collaborative work environment by communicating and consulting with members of the health care team, as well as to act accountably by charting what they do and events that they witness (Registered Nurses Association of British Columbia, 2003; Canadian Nurses Association, 2002). In this anecdote, as in others, nurses are reluctant to interact with

midwives. Are midwives and their clients viewed as strangers in their familiar work environment? Strangers can be threatening and unpredictable (Bauman, 1993). If so, what experiences might help to turn these strangers into friends and colleagues?

The midwife relating this anecdote also seems to have taken a path of avoidance, putting distance between herself and the staff nurses. She did not seek to communicate her specific needs for assistance to the nursing staff directly. Might they be better remembered and implemented if she had? She does not state why she chose to communicate through the nurse clinician; although a clinician's job is to teach and introduce new approaches, expectations and policies to her fellows. Nevertheless, the passing on of this task created distance between the midwife and the staff nurses. How the nurses, and the midwife herself, understood this distance is unknown, but the separation is evident and obviates a lack of intent to come together as a true team. Team members work in proximity and share collaboratively in a particular purpose, each contributing their part in coordination with the others. This distance, shown in the nurse's disengagement with the midwife and her client, and then exemplified by the midwife's dictation and announcement-by-proxy of her expectations, precluded dialogue and mutual contribution, inhibiting a sense of team.

Missing a Sense of Team

When the labours of midwives' clients' are less straightforward, and medical intervention is required, midwives often rely on the assistance of nurses more extensively, requiring them to participate in their clients' care for much longer periods than just at delivery. Such situations might include induction or augmentation of labour through the use of intravenous oxytocin, epidural anesthesia, or preparation for a

caesarean section. Midwife Val describes her expectations of nursing support when a client is admitted to the hospital for induction of labour.

> I say to the nurses, "It's not my job to get the women into labour. It's your job to get them into labour. It's my job to be there when they are in labour. So if we are inducing someone, I want to be called when they are in active labour. I have to be there for my client when they need me the most. I don't want to get tired trying to get somebody into labour when I should be available for them later when they really need me. I'm the primary caregiver. I have to make decisions; I have to be on when the baby is being born. There are other issues then, so I need to protect myself during the early labour." And I think most of the nurses understand that. But I think some of them really don't get it. (Val, midwife)

This explanation of the midwife's need for nursing assistance when a client is to be induced is understandable and emphatic. She provides a clear rationale for why she cannot be with her client constantly before and during early labour when the client is likely to need minimal support. The task of monitoring the woman's response to the oxytocin and the status of her fetus, as well as titrating the intravenous drip, takes knowledge of the drug effects, good assessment skills, and is considered a case for one-on-one nursing care (British Columbia Reproductive Care Program, 2005). The midwife implies an expectation that the perinatal nurses to have this knowledge and skill and assumes that one nurse will be available to stay with her client until she is required. However, she indicates that this assumption is, on occasion, not well founded – "some of them really don't get it." For physician patients, nurses are accustomed to initiating and managing oxytocin inductions right up until delivery. What is it about Val as a midwife

that may cause some nurses to view their responsibility toward her and her clients differently? Val's following anecdote illustrates an experience of nurses' apparent ambivalence regarding this responsibility and its implications for midwives and midwifery clients.

> I had a client about a month ago who was being induced for post dates [far enough past her due date to cause concern]. I met my client at the hospital at about eight in the morning, started the oxytocin, and then went to the clinic and did a full day. I came back at five to check on my client, and she was still just niggling [having frequent, mild, ineffectual contractions]. The nurses hadn't upped the oxy! In two hours there had been no increase of the oxytocin! So I was mad, and I said to the nurse who was on – a junior nurse who is a bit uppity and a little over confident and full of herself – "How come the oxytocin hasn't been upped for two hours?" And she said, "Well, she's contracting every three minutes." And I said, "It doesn't matter that she's contracting every three minutes, she's talking through them; she's not in labour. You need to be more aggressive with the oxytocin. This woman needs to be in labour. She's not contracting strongly enough." But the nurses said they couldn't do it because they were too busy. So Dianne, my conditional registrant, stayed with my client and upped the oxytocin after her day of doing home visits. I went back to the office and did two hours of paperwork.
>
> At about seven-thirty I came back to the hospital. Dianne said, "She is starting to feel them [the contractions] a little bit." So I said, "I'm taking you for dinner. You get dinner." Like, we'd both been working *all day*. But first I sat with

my client for half an hour before we left, just to assess things. So it was about eight o'clock when we left for dinner. And a nurse came up to us, kind of blocking the hallway. I said to her, "We need to go. I'm taking Dianne for dinner." The nurse said, "Well we're really busy. There are only the two of us, you know." I looked at the board, and there was one person delivered, one person in labour, and my client. I said "You've got two patients, mine and the one in labour. The third person is going out to the ward. What's the problem?" "Well, we're really busy." So I said, "We are going. Call the supervisor. Do something. You don't need somebody to sit by my client's bed. She needs to walk the hall. You can up the oxy in half an hour and we'll be back in an hour." I was furious! (Val, midwife)

This midwife's story reverberates with remembered fatigue and annoyance. A full day had gone by; she worked seeing other clients in her clinic, waiting for a call from the hospital to tell her that her client was in labour, only to find that the nurses failed to fully engage in her client's care. From the midwife's perspective, the nurses did not seem to grasp her concern that her client was overdue, facing potential associated risks and so needed to be expedited to labour and deliver. However, perhaps she did not know or fully consider the conditions under which the nurses were working that day. They may have been aware of the urgency, but because of their busy workload unwilling to aggressively increase the oxytocin when they could not be at this woman's bedside consistently. If this was the case, it is difficult to understand why the situation was not communicated to the midwife in a timely way. When confronted, the nurses resorted to self-interested defensiveness and the midwife to domineering directives and anger. Regardless of the

circumstances in this situation, clearly evident are the lack of reciprocal, respectful communication and negotiated understanding regarding the responsibility for this client's care. Related to this, once again, is a missing sense of mutuality and teamwork between the midwife and the nurses working that day.

'Team' has two primary meanings: the bearing of children, or progeny; and two or more people (or animals) who work together to achieve a shared goal or task (Simpson, et al., 1989). 'Team,' then, is an especially appropriate term with which to refer to those who work together to assist a childbearing woman. The word has both the literal connotation of childbirth and the figurative meaning of the cross-fertilization of knowledge, creativity, and hard work for a fruitful outcome, as occurs in productive teamwork. That is, a team is the coming together of individuals in shared work, with a shared intent, to bring an endeavour to birth. 'Teamwork' is effective, efficient, cooperative action by a group (Simpson, et al., 1989). For this to occur, for teamwork to be present, there must be communication, negotiation, and a willingness to seek consensus, or at least satisfactory compromise. Implied in this is mutual respect for what each brings to the team effort.

Human teams are usually heterogeneous in that they are a combination of people who each bring a particular strength, gift, or perspective to the task at hand. This is particularly true of the healthcare team, which includes a number of relevant practitioners from various healthcare disciplines as well as the patient/client and possibly members of her family. Inevitably there is effort involved in finding shared meaning, clarifying goals, and in resolving differences between members. However, where respect for one another is shown, the ability of team members to hear, understand and negotiate is enhanced to

benefit not only the shared purpose that brings them together but also the team members themselves in the building of trusting relational bonds (Lingard, Reznick, DeVito, & Espin, 2002; McWilliam, Coleman, Melito, Sweetland, Saidak, Smit, Thompson, & Milak, 2003; Schober & McKay, 2004).

In this midwife's anecdote those who could be considered members of the team are: Val, the midwife herself; her client; Dianne, Val's conditional registrant; the nurses; and, in the background, the physician who would have been consulted regarding the induction; as well as the members of the client's family. The midwife's description demonstrates an assumption that the nurses and the midwives, specifically, would play roles in facilitating the client's labour and birth; but, in this situation, the elements of teamwork, or even the sense of being a team, were largely missing. In addition, although the presumed concern of all involved was the woman and her need to birth her baby, she was eclipsed by the conflict over who should be responsible for running her induction and how this would occur; a struggle over which group of caregivers' personally perceived needs should be met. The needs of all – for labour, food, rest, and extra hands – were, no doubt, very real, but the respectful communication and trust needed to keep the woman central and negotiate the meeting of these needs was missing.

Needing Help – Placating the Nurses

Darya, another midwife, describes other circumstances when the assistance of nurses may be badly needed, and how assumptions confuse and create discomfort and conflict for those involved. She begins with the example of an at-home labour that is not progressing well, perhaps due to the woman's fatigue and slowing or weakening contractions. In such cases the midwife may have been working with and offering support

to the woman and her family for many, many hours. To move the labour along, the midwife might bring the client into the hospital for an augmentation of labour with oxytocin (similar to an oxytocin induction) in order to expedite delivery, and epidural analgesia so that the woman can get some pain-free rest in order to reenergize her body. Here is this midwife's description of what such a situation is like.

> When we bring clients into the hospital we kind of share the nursing care with the nurses to some degree, and that's a really difficult one. This is one of the nurses' big complaints; they don't like that situation. They actually want us to do our own epidurals and our own augments; but we don't want to do them for two reasons. One is that by the time we get an epidural and an augment, we're usually exhausted and we actually want the help. At least we want to sit in the chair and just doze off for a few minutes. The other is that as midwives we don't do that many epidurals and augments in a year, and we feel like we will forever be asking, "How does this pump work? What are we doing now? What's the protocol?" (Darya, midwife)

As in the previous midwife's descriptions, Darya clearly explains why the assistance of nurses is needed to administer these medical interventions. The nurses resist and have let her know that they expect midwives to have the skills as well as knowledge of the technology and hospital protocols to manage epidurals and augments as nurses themselves do. Or, perhaps if they do not, that they are responsible to acquire these skills so that the nurses do not have to do this work for them. Are nurses not aware of, or do they resist acknowledging, the reasons why midwives like Darya do not want to take on this aspect of care; that is, the need to hand some things over to the nurse so that the

midwife can recoup her mental and physical resources? Why do nurses not like to be asked to assist in this way? Once again, it could be the busyness of the unit; but the midwife's client should be, in terms of workload, a patient accommodated like any other. Perinatal nurses are generally aware that the midwifery model of care includes midwives' commitment to continuity of caregiver. Given this knowledge, it is logical to consider midwives able and responsible to do for their clients what nurses themselves do for patients. They may wonder why the midwife has the option to rest while they do 'her work.' Or, why she is unwilling to perform the skills that they consider basic to patient care. Nevertheless, as discussed in analyzing midwife Val's anecdote above, the reality is that the labouring woman, once admitted to the hospital, is a nursing patient as well as a midwifery client. Nurses are accountable to provide care to this woman and her baby as is necessary and requested by the primary caregiver. It is logical then for the midwife to expect a nurse to assist her by contributing to care for her client through the activities and skills that the nurse is expert in and accustomed to providing to other patients.

This midwife speaks of sharing "nursing care". There are two senses in which this term may be understood. First, as a supportive presence with the woman and continuous monitoring of her response to and progress through labour, as it is the type of caregiving that both nurses and midwives offer; the crossover in their caregiving roles. If so, why does she not call it 'midwifery care'? Secondly, it may mean the administration and monitoring of medical interventions framed as "nursing care" because it is taking place in a hospital due to needed intervention and so, necessarily and justifiably involves the support of nurses to carry out technical skills and management. The midwife needs this assistance, but is also obliged to do as much in regards to the intervention as she can by

nurses' reluctance to participate and assist her. In this sense, to call this management of medical interventions "nursing care" would suggest that it is not integral to the midwifery role.

Emerging from the midwives' anecdotes is midwives' understanding that they are different from nurses and different from physicians, but that the expectations of nurses' assistance should be the same as when assisting a physician. This constitutes grounds for confusion. Might nurses who do not have knowledge of the philosophy of midwifery care hear midwives' understanding of themselves as combining the nurse and physician roles? If so, they may expect midwives to be capable not only of prescriptive decision making – that is, the ability to recognize that medical intervention is necessary and the authority to make it happen – but also the skills to initiate and administer, at least, the interventive measures that nurses themselves consider a part of their skill-set.

As if in answer to such an understanding the midwife implies that interventions such as augments and epidurals are rare for midwifery clients because they generally do not need them. Are there differences in the ways in which midwives and nurses guide women through labour, or in the women themselves, who choose midwifery care over care by physicians and nurses? She says that usually by the time a woman is in need of intervention to recharge a stalled labour the midwife is exhausted, suggesting that a great deal of time and effort have been spent using other means to facilitate the woman in her labour. James (1997) describes the intensity and commitment of the relationship between midwives and their clients as complex, woman-centred, deeply embodied, trusting, and rooted in time spent together during pregnancy. She also describes the undistracted focus and attention the midwife gives to the labouring woman, informed by her connection with

and understanding of her as an individual. The decision to utilize intervention in the midwife's example ultimately would have been arrived at after much effort spent on facilitating the progress of labour in other ways.

Nurses also care for labouring women with similar compassionate single-mindedness, doing all that they can to facilitate a birth experience that achieves the woman's hopes and desires. However, intense as this relationship may be, it is time limited and not generally undergirded with the degree of mutual knowledge that a midwife-client relationship is. In addition, perinatal nurses are accustomed to engaging with women within an institutional environment, under the ostensible direction of physicians. The nurse-patient relation is always played out against the backdrop of medical knowledge and technology, and the assumption that these tools, when needed, are the primary means that should be employed. In addition, for nurses as dwellers in hospital, there is an allegiance to the place, its workings and efficiency, and to the social interaction with co-workers that it offers. All of these things can divide a nurse's loyalties and serve as distractions. For this reason, nurses who are asked to assist a midwife may not understand the amount of energy and negotiation that has been expended before arriving at the hospital to avail a midwife's client of interventions, or of the ongoing mental and emotional work the midwife is to give to her client's delivery.

Following from what midwife Darya says regarding the rare use of medical interventions, midwives are far less familiar with the concrete steps for actually applying them. Understandably then, managing technology would serve as a frustrating distraction and leave them with less time to focus on the labouring woman, possibly even contributing to a lack of safety and proneness to errors. Intravenous infusion is another

intervention that this midwife rarely has an occasion to initiate. If needed, she is once again often reliant on nurses to employ this skill for her.

> IVs are a really good example of another place where midwives feel fairly insecure because, unless you have spent time nursing and doing lots of IVs, when you do them very infrequently you just never feel that great with the skill. And I think that's a big anxiety for a lot of the midwives, this stupid IV thing. We have a couple of midwives who did nurse for a long time, and they are very, very comfortable with the skill. But the rest of us tend to think, 'Oh boy, here we go. Let's hope we get this one in.' You feel a bit stupid, you don't want to make your client uncomfortable, plus, when we need to put in an IV, you wouldn't believe how many other things we are supposed to be doing at the very same time. Usually when a client needs an IV it's because we've got a dystotic labour[6] and I'm calling in the consultant, doing the paperwork, and trying to reassure the woman. That is something that just drives me crazy! I'm doing so many other things and along with all those things I now have to try to attempt something I know I'm not that good at. That's the worst part. However, in our hospital the nurses don't like it if we ask them to do it. So, and to be fair, I do want to get better at the skill. I am getting better at it. I generally make an attempt, unless I look at the veins and know that I can't. But you are expected at least to give it a try. (Darya, midwife)

A midwifery client's need for an intravenous infusion is usually just one part of a cascade of interventions. Many concerns are on the midwife's mind at that point, but

[6] Dystotic labour: a labour that is not progressing, for any of a number of possible reasons, and will likely require medical intervention; labour dystocia.

central to her responsibility is safety for the woman and her fetus, and providing support to enhance positivity and minimize fear and trauma in the experience. To add to this, the anxiety, frustration and embarrassment of having to execute a skill that she is not confident with seems imprudent when there is a nurse who may capably do it while the midwife continues to give energy to her central concerns. However, as in assisting with other interventions, this midwife says that nurses do not like to be asked help in this. Is it worth making this request to interrupt others' work and bring someone who may emanate annoyance into the room to perform a task with perfunctory disengagement? Or better to struggle through the embarrassment of attempting an IV start herself?

The midwife is willing to perfect her ability at this skill, but on whose behalf? Her words suggest that this will act as a placatory gesture in the nurses' direction. She will at least partially meet their expectation that she take on a more medically oriented role; and in this become more like them. Why is this necessary when, presumably, a nurse has been assigned to work with her? What has prompted her to acquiesce, and in doing so to allow the nurses to both maintain their distance and control the amount of assistance she receives? As in the accounts of the other midwives' experiences, the evident reluctance of some perinatal nurses to engage in the shared care of childbearing women with community-based midwives represents a thorny and frustrating obstacle to the ease, harmony and joy that ideally surrounds a baby's birth, regardless of the setting.

Nurses' Experiences: Interacting with Midwives

Like the midwives, most of the nurse participants in this study chose to describe difficult interactions. They too spoke of experiencing unpredictability and uncertainty

when assigned to work with midwives and their clients. The differences in philosophical views and perceived risks of childbirth contributed to feelings of unease and concern, while the degree to which their expertise and contributions were felt to be constrained by midwives was a source of resentment and frustration. In addition, the relationships between midwives and their clients were often seen to be exclusive and unwelcoming of most supportive contributions by nurses. The nurses spoke of feeling redundant, mistrusted and resented for their medical approaches. Interactions with midwives and their clients created confusion as to their roles and agency. Their anecdotes also betray ongoing struggles for control and authority.

Feeling like a Third Wheel

For Jenna, a perinatal nurse, the experience of interacting with midwives is markedly different from the experience of collaboration she is accustomed to with physicians and the role she, as a nurse, plays in caring for physicians' patients.

> In my experience working with midwives I feel like my autonomy is encroached upon. When you're working with a doctor's patient, the doctor isn't there. You do it all. You admit the woman you examine her, you talk to her about pain control, you find out what her hopes are for this labour. You find out what is going on and what kind of experience she has had before with labour. And then you just call the doctor in as you need them most of the time. And I like that. I like having that autonomy. That's one thing I like about nursing in the perinatal setting; that you are on your own. You know, the doctor will call and ask you, "What's going on? What do you need from me? How are things? Whereas with midwives, they are there all the time and I often feel like a third wheel. (Jenna, perinatal nurse)

Jenna describes what she loves about perinatal nursing with enthusiasm. During the time of a woman's labour, delivery, and recovery she has the opportunity to know her patient at a remarkably intimate level. Without overstepping the boundaries appropriate for nurse-patient relationships she uses this opportunity to learn and incorporate all that she can of a woman's expectations and relevant history in order to facilitate a positive experience for her, her baby and family. Depending on the fit between nurses like Jenna and their patients, the power of this relational attention can be intense and deeply memorable for childbearing women (Simkin, 1991, 1996).

This nurse enjoys the fact that physicians with whom she works trust her assessment, care and judgment and will respond to the information she provides them for the patient's wellbeing. Her role is to be with their patients in their stead using her nursing expertise to provide care for women in a way that they themselves likely could not. Patients become her patients as much as the physicians' during this time. There is a note of pride and satisfaction in Jenna's words, a celebration of herself as a nurse and of the contribution she makes to the process of birth for her patients. This is starkly juxtaposed to her experience of sharing the perinatal care of women with midwives.

What does it mean to feel like "a third wheel"? Bicycles, when skillfully balanced, run smoothly on two wheels, negotiating twists, turns and varied terrain. Tricycles may also be serviceable transportation but are less stable, more likely to tip over when turning, and less able to accommodate anything but a smooth track. To extend the metaphor, the midwife and her client are two wheels accustomed to traveling together through pregnancy and on the road to birth. The nurse may feel that the addition of her presence is perceived as redundant, or even as a threat, throwing things off balance,

impairing the progress and agility of this journey, the direction for which is determined by the midwife and woman in their alignment. In assisting a midwife, the nurse has little or no decision-making power or control over the course of events, but must follow along. Interestingly, this metaphor is an inadvertently erroneous use of the colloquialism 'fifth wheel,' which means a wheel that is idle, not contributing to work (Simpson, et al., 1989). Yet, the image of a third wheel is perhaps more accurate, because this nurse is present to do her best to contribute to the caregiving; however, it seems that she feels her actions are out of place, perhaps seen as veering in another direction.

This nurse's analogy is in striking contrast to the confident independence and full use of her scope of practice that she describes in caring for physicians' patients. What she does not comment on here are the many times when the relationships between nurses, perhaps herself included, and physicians are difficult, coloured by stereotypical thinking, power dynamics and disrespect. However, a difference when nurses' relations with midwives and physicians are compared, and perhaps one reason why this nurse chose to describe her relationships with physicians as generally good, is that nurses and physicians enact their roles within a common paradigm. Their professional relationship has a deeply connected tradition and history and they are in many ways accustomed to the predictable idiosyncrasies of one another's professional comportments. In the room with the midwife and her client, the nurse is the stranger. She may feel void of purpose and out of synchronicity with the labour and birth. What contributes to this feeling of being out of alignment with midwives and their clients?

The Bad Medical Person

As nurse Jenna continues, her words elucidate further what she understands as the source of her feeling of estrangement. In addition to possible redundancy and dislocation, she finds herself troubled by what she perceives as midwives' and their clients' assumptions about her.

> I have often felt that when I walk into a room where a midwife and her patient are that they have had months to establish their relationship, so they are really close. It's great and I like the concept of that continuity of care and that closeness. My presence in the room – and I don't know if it's the patients that the midwives attract or what – but they don't want any kind of intervention. Which I can totally appreciate and would go to the end of the earth to support if that is their goal. But when I walk in as the nurse, I often feel like I'm seen as the bad medical person who is going to come and interfere. Do you know what I mean? And I really resent that because that is not...We are all there for the same purpose: to have a happy mother and a happy baby. So it doesn't feel like a team to me very often. And I think that the agendas are often very different. I have a hard time with that. A lot of them are really nice people and they do a great job. But I think the philosophy is different, for me anyway, in my own practice. (Jenna, perinatal nurse)

Elaborating on her sense of misfit when she enters the midwifery space, the nurse suggests that those present view her as someone who might "interfere" in what is going on. To interfere is to collide, strike against, clash, hamper or hinder (Simpson, et al., 1989). This is the antithesis of the 'happiness' she is there to facilitate as a perinatal

nurse. Jenna feels that she is seen as "bad," potentially conflictual; someone whose presence might create a rupture in the flow between the midwife and woman and bring discord to the harmonious process they are about. She feels judged for meddling by just being present in the room. Her indignation at this assumption is understandable when her professional objective would be responsibility and helpfulness. Nevertheless, she acknowledges the barrier between herself, the midwife and client in the observation that midwives and their clients come with a "philosophy" different from her own. If she is correct in this observation, are she and the midwife, in fact, "there for the same purpose"? Yes, as she has stated it; but perhaps also, no. For example, do the midwives that this nurse encounters share the same understanding and perception of risk and risk reduction that she has? Would she, as the nurse, share the same understanding of the caregiver-client relation, or even the mother-baby relation that many midwives have? As she suggests, without an understanding of one another's approaches and purposes a true sense of teamwork is unlikely.

The meaning of the different 'agendas' and 'philosophies' that this nurse alludes to are not explained. However, if being medical is 'bad' then the implication is that a more 'natural' or holistic philosophy and agenda for childbirth may be what the midwife and her client ascribe to. That is the view of childbirth as either naturally ordained and generally accommodated by women's psyches and bodies, as opposed to an event that women not only need assistance with, but also is perilous, fraught with risks and dangers. Related to this is the understood wisdom of, or attachment to, different approaches and acceptable locations for childbirth. A medical approach might be said to incorporate medical intervention as the normal and appropriate facilitation of what is natural; and a

midwifery approach might incorporate intervention only when the natural fails. The difference is subtle but profound. Nevertheless, practitioners holding either philosophy can and need to work together effectively for the benefit of the woman and baby. Not only an open acknowledgement of these differences is needed, but also willingness to build respectful bridges of understanding that can accommodate one another's approaches, always keeping the woman and baby at the centre are needed. As has been shown, without this intentional relationship development between the caregivers, interface between nurses and midwives can be awkward, isolating, and/or abrasive; a source of misunderstanding and confrontation.

Grey Areas

Ironically, it is also the overlap in skill-set and expertise between nurses and midwives that contributes to Jenna's feeling that, with midwives, teamwork often does not occur.

> We're assigned to the midwife's client and I think this is when another sort of grey area happens. The role, even though my name is on the chart and I am legally part of this case, I'm very hands off. The midwife is in the room most of the time; she is doing auscultations, or monitoring or whatever, so she is primarily responsible for that patient. And my job is break relief, and in second stage I'm there. But I'm the nurse. Like, I'm very comfortable working with medical staff. Our roles are very different. We have two separate tasks in the same location. Whereas midwifery crosses that line a little bit and so it's hard to know, as a nurse, what my role is. As an obstetrical nurse you can so easily get what you want per se. Like you can say to the medical staff, "Listen, I'm not happy with

this, and I need help here; or, how about this? I don't like this fetal strip; can we put on a scalp clip?" So, you know, you are the determining...In a lot of ways you have a very direct impact on how that care is going to go. But with the midwives you don't have that much control. I think it's harder to sort of have your suggestions or your input put into practice. And it's hard when you feel uncomfortable, maybe, with what is happening with the care. (Jenna, perinatal nurse)

The nurse speaks of her role when assigned to a midwife's client, as a 'grey area' in which her practice is constrained by unarticulated boundaries; she is uncertain of others' expectations. A grey area is an indeterminate area that lies between two different, often opposing, positions, and does not conform to any existing set of rules or dictated patterns of behaviour (Simpson, et al., 1989). The grey area Jenna identifies is both within her and surrounding her when she enters into the midwifery space. She is suspended in a kind of limbo between what she sees, understands as a nurse, and the uncertainty as to whether she has permission and authority to act. It is difficult for her to bring her expertise into play, and she suggests that her place with those sharing in the birth is undefined. When working with physicians she speaks of the 'black-and-white' of their roles. These are defined by a combination of policy and familiarity with the mores and relationships within the perinatal area of the hospital where she works. Although the sense of true interprofessional teamwork with physicians no doubt varies, her role definition encompasses a taken-for-granted degree of influence and status in relationship with them and their patients. What little she knows of midwives' expectations is that she is to be available at specific times. Is knowing that one is to be in attendance the same as

providing care as a nurse? Her words suggest a state of reticence and passivity. In these circumstances, if the nurse's role is exemplified to the midwife and client by the limited scope of responsibility and action they witness in her, might she be defined as a 'nurse' for them by this diminished and limited exercise of expertise? Some nurses may feel that they are not needed and so shed all but the minimum responsibility in working with midwives. Jenna speaks as though she accepts this assigned responsibility; however the silence and lack of agency she describes is perhaps frustrating and distressing, "it's hard," she says, particularly when she is concerned about the decisions made and care given.

If she is correct in what she says about what some midwives and their clients think of her; that is, as someone who might interfere and whose contributions to care, except as directed by the midwife, would be unnecessary or disruptive; then this might well call into question her nursing identity. When she says, "But I'm the nurse," what is signified? Does this mean that she is out of place in the midwifery space? Or, is it a statement of self-assertion? Perhaps it is a plea to be given the freedom to act within her accustomed role. From the previous anecdotes it is clear that, at times, a power differential exists between nurses and midwives that is egregious for nurses. However, midwife Darya's account above suggests that midwives, too, may feel challenged when nurses are in a position to point-up their lack of certain 'medical' and technological skills specific to the hospital setting. Expectations, comparison and criticism can lead to rivalry, which in turn feeds mistrust and disrespect, objectification and estrangement between these two groups of caregivers.

Stuck in the Middle

In the following account there is a disagreement over the authority of professional knowledge and confusion regarding responsibilities. Vivian, the nurse who relates this account, begins by raising the need for the clear delineation of roles and mutual understanding regarding boundaries and control.

> I would say, yes, there have been times when the interpersonal interactions have been a barrier for patient safety. I think a lot of it... I think we are probably still not finished, but there have been a lot of growing pains in terms of... I think most of it, for me, is about establishing boundaries and scope of practice. That's the crux of the curve from what I've observed. Miscommunication, misunderstanding about control, is what... (Vivian, perinatal nurse)

The pauses and fragmentation in this nurse's attempt to articulate the interface between midwives and nurses suggest the uncertainty and awkwardness of the evolving and elusive margins of their interactions She reveals the relation between them as tentative and unpredictable through single words and partial phrases: "growing pains," "boundaries and scope of practice," "miscommunication," and "misunderstanding about control." Yet there is no stated certainty as to what is desired were they to glimpse the heart and purpose of this relation. She sees a need to define and circumscribe, to build walls around responsibility; but what exactly is to be included or excluded? Could these boundaries be fluid and permeable enough to accommodate comfortable sharing of roles? Her words imply that jurisdiction over the labouring woman and fetus is the contested ground and that clarity and certainty are, for her, related to ensuring their safety. For nurses, as for all healthcare providers, this is of utmost importance. Where threat to safety

is perceived, it is the justified subject of concern and moral distress. So, it is understandable that here, as in previous anecdotes, that concrete spelling out of expectations is important to this hospital-based nurse.

Rivalry, contested authority and control regarding safety-related judgments, and the most prudent actions to take, may be perpetuated even in situations where a nurse is called on specifically for her knowledge and expertise in the assessment or care of a midwife's client. Vivian goes on to tell of a situation where a nurse's invited efforts to contribute to care were in the end disregarded.

> One example that comes to mind, when midwifery was first integrated – and this was when I was working in a smaller community on the lower mainland – there was a situation where the nurse was called in to interpret the monitor strip because at that point the midwives were not credentialed to be interpreting them. And the nurse was concerned about the fetal heart, but the midwife overrode her concerns and got the patient into the shower, you know. And that, to me, sort of epitomizes what the dilemma often is. The nurse is kind of stuck in the middle sometimes. If you are going to put the nurse in a situation where they have got autonomy over the monitor strip, or over the epidural, or over oxytocin that really means that they should be in charge of what's happening. Because it's pretty hard to separate those functions from what is going on with the whole experience. It's pretty unfair to put the nurse in that position of being responsible for only that part, but not the rest. And especially when, because of inexperience or lack of judgment or plain disagreement about what is going on, there is... And this is where it's different from the general practitioners' role, because we don't have that sort of piecing

together of functions when you have got a situation where a GP is looking after the patient. The nurse is handling the epidural, the oxytocin, the activity, and you are not going to find a physician that's going to say, "Oh, shut everything off and put her in the shower," you know, that kind of a thing. So I think some of those things are still in the process of being worked out. (Vivian, perinatal nurse)

Is the "middle" where a nurse may find herself the untenable position of being unable to remain uninvolved, yet also unable to be fully involved? Though asked for the benefit of her expertise, the nurse was not invited to engage fully with the woman as a caregiver, to be part of "the whole experience." In addition, the importance of her concern regarding the wellbeing of the fetus was seemingly discounted. How is a nurse in this position to respond? Does she follow her professional commitments to insure the safety of the baby? Or, does she acquiesce to the primary caregiver's judgment of the situation? Vivian states that to put a nurse in such a position of impotence is unfair. It is also disrespectful of the nurse, once again pointing up the ambiguity of the nursing role in interaction and shared work with a midwife and her client. Like Jenna, above, Vivian juxtaposes this uncertainty with the routine of caring for a physician's patient.

This nurse also speaks of being "stuck in the middle," as a "dilemma," a perplexing situation between two unfavourable alternatives, a place of ethical dissonance. What does this mean in this situation? One fork of the dilemma is the nurse's duty and responsibility to assure patient safety, based on her conviction that her interpretations, assessments, and judgments are accurate and vital to it. This might compel the nurse to intervene and take control in the interests of protecting the baby when she sees evidence of fetal distress on the fetal monitor strip. The second alternative derives from the

woman's autonomy in choosing the midwife as her primary caregiver. As such, the midwife, with permission from the woman, has ultimate jurisdiction over events. It would therefore be the midwife's prerogative to respond to or disregard the nurse's assessment and suggestions. What might have happen had the nurse in this case insisted on intervention we cannot know. Is there any way to avoid such a dilemma?

To be in the middle as described here is a negative and seemingly powerless position. Only one of them could assert dominance and in this case the nurse fell into the weaker position. This is a dichotomous analysis of this place in the middle. However, there are other ways of viewing this position. How might the situation have been different if being in the middle was viewed as a position of strength and opportunity? The middle is a pivot point from which change can be made in any direction. It is the fulcrum by which the balance of diversities can be achieved. The middle is, ironically, a liminal position, like the margin, because by virtue of its openness and lack of commitment to any side it sits in the midst of possibilities, outside of opposing poles. From this vantage point a rigid dilemma may well dissolve into an awareness of many possible opportunities to be considered. If the nurse had been able to understand herself to be in this open middle, her understanding of others might have been very different and an opportunity for creative solutions found. The nurse enters into the midwifery space as an intermediary of the hospital and the medical paradigm that it represents. However her role is to facilitate, in a way that is harmonious, the events in this space that has been shaped socially and epistemologically by a different paradigm. In this role she is positioned as the host in her dwelling place, available to meet the needs of the midwife and her client. As such it could be considered her obligation to attempt to create a sense

of equipoise across the differences of understanding and approach. This is not necessarily an easy position to choose. Mediation may seem a daunting task requiring courage and the testing of one's fidelity one's own values and certainties while receptively considering others.

Gadamer (1997) offers a way to stand with integrity in this middle position of openness and to discover that it is a place of growing understanding. This way is through dialogue, which is the dance of question and answer. The questions, however, must be authentic questions if they are to elicit meaningful answers. A true question is one which "breaks open the being of the object" (p. 362). That is, it opens a window onto the being-in-the-world of what is questioned, which is experientially, historically and philosophically shaped. In asking the questioner reveals "the questionability of what is questioned" (p. 363). A desire to know, genuine interest and curiosity, the openness of the questioner to hear an authentic answer characterize an authentic question. This initiates true dialogue, which "consists not in trying to discover the weakness of what is said, but in bringing out its real strength." (p. 367). The questions, though open to the unknown possibilities of the answers, are inevitably circumscribed by the horizon, the being-in-the-world, of the questioner. In this way her own presuppositions and prejudices are "brought into play by being put at risk." (p. 299) Rather than denying her values, beliefs, and accustomed approaches, her questions are forged out of them, but with the anticipation that they may be in turn questioned. In this way, as Gadamer says, true dialogue "is not the art of arguing...but the art of thinking" (p. 367). That which is known by those engaged in dialogue is brought into a "state of indeterminacy, so that there is an equilibrium between pro and contra" (p. 363). The middle, then, this place of equipoise, a

place of wonder and of growth. It leads to understanding, but not necessarily through an amalgam of views that denies diversity; rather, as Irigaray suggests, through

> "the ability to say oneself to the other without for all that forcing upon the other one's truth. The ability to listen to the other as well, to hear a meaning different than the one from which a world of one's own has achieved its course." (Irigaray, 2002, p. 8-9)

How might such dialogue be realistically implemented in the day-to-day interface between nurses and midwives? A situation like the one described by nurse Vivian demands concrete actions, but which, and whose? From which understanding of childbirth? Was the risk to the fetus that the nurse perceived actual? Did the midwife have some inherent knowledge of this woman and baby that the nurse lacked and perhaps could not comprehend? Applying an understanding of dialogue such as that proposed by Gadamer, the nurse and midwife here, and in the other accounts explored in this chapter, could have met one another respectfully, asking and listening, true to themselves, but also willing to suspend for a few transformative moments their unquestioned assumptions.

The Relational Maze

The descriptions and anecdotes in this chapter have shown the difficult, self-perpetuating discomfort, ambivalence, and conflict between nurses and midwives in many situations of interaction over the care of midwives clients in the hospital setting. In their journey toward shared work for the benefit of childbearing women barriers seem to arise in the path that render one another's voices unintelligible, impede progress and send them back, searching for the way down habitual and familiar paths shaped by hierarchical

thinking, the taken-for-granted rightness of given approaches and assumptions, and expectations about how others will reason and behave. When differences or discomfort are encountered, relational distance and avoidance, or tight-lipped resentment, are often chosen in lieu of the demands and potential vulnerability of seeking a way through dialogue and proximity. In this, and because of differences in their understandings of birth and the priorities foregrounded and inured by their professional socialization and practice paradigms, they remain strangers to one another, choosing to safely withhold the sharing of themselves and showing little interest in knowing the other. Engagement is avoided as is curiosity about the other's subjectivity. To show an interest, to ask authentic questions, is to open and to commit to welcoming what the other has to share; to be hospitable to the other's thoughts, knowledge and experience. This would mean choosing to explore the maze of interprofessional relation together, making passages through the barriers, seeking and negotiating the ethical path that will lead to a truly mutual focus on the women and their babies.

CHAPTER SIX

IN SEARCH OF ETHICAL COLLEGIALITY

The Ethics of Collegiality

Who are colleagues? They are those who work together in some particular position or employment for which they are 'chosen' together. By virtue of this they belong together and of necessity have a relationship with one another (Simpson, et al., 1989). This definition suggests that collegiality as a relation between colleagues is positive and that each is valued by the others. In this regard, colleagues are like friends when engaged in their shared work. Although the intimate aspects of friendship, and even the clear sense of liking, may be missing, ideally colleagues are for one another helpers, supporters, and kindly rather than hostile (Simpson, et al., 1989). The meaning of collegiality, then, is much like the sense of team discussed earlier. Teamwork requires a degree of collegiality between team members. What are the ethical dimensions of the collegial relation? How do they contribute to the strength and effectiveness of the shared work of an interprofessional, perinatal, healthcare team? Based on participants' anecdotes and accounts in this chapter, I maintain that mutual respect, empathy and compassion, are essential to ethical and collegial, interprofessional relations, as are open communication and the willingness to dialogue about difference. All of these contribute to a climate of mutual interest and inclusion and are substantially supported as aspects of successful collaboration in the literature (e.g. Hall, 2005; Harkness, et al., 2003; Schober & McKay, 2004; Stapleton, 1998).

On the basis of my conversations with the participants in this study, I am confident that every one of them is frequently motivated in their work by compassion. They are committed to providing what they believe to be the best possible care to their clients and patients, given circumstances and resources available to them at the time, not only by professional codes but by a genuine emotion-based moral response. What is troubling is that this compassion, and the engagement and respect that it evidences, is not always extended toward other care providers. Nussbaum (2003) suggests that three judgments must be present for an individual to feel compassion for another: first, "the judgment of *size*", a belief that whatever the other is 'suffering'[7] is significant; second, "the judgment of *nondesert*", a belief that the person did not deserve the 'suffering'; and third, "the *eudaimonistic judgment* (this person, or creature, is a significant element in my scheme of goals and projects, an end whose good is to be promoted)"[8] (p. 321). This third judgment is especially important to the ethics of relation and collegiality because "it involves valuing another person as part of one's own circle of concern" (Nussbaum, 2003, p.336). Nussbaum (2003) suggests that this is not a purely egoistic concern, but entails both wonder and curiosity, emotions that first call us as children to interact with the world and the face of another. The inclusion of another in my circle of concern with feelings of wonder and curiosity is perhaps not ethical per se but is "highly relevant to morality" (p.337). When the moral impulse of compassion motivates me to act towards another in ways that are beneficial to them it becomes an integral part of moral action. Nussbaum (2003) delineates shame, envy and disgust as impediments to compassion. It is

[7] I use 'suffering' here euphemistically to mean any real or potential stressor that inspires one to feel concern for another.
[8] Eudaimonistic – from the Greek for *good* or *happiness* (eu), and *divine spirit, principle, or agency* (daimon) (Simpson, et al., 1989)

these emotions that allow us to objectify others, to see them as less than human, and so to be disinterested in their suffering or to feel that it is, after all, deserved (p. 342-353). In many of the anecdotes that follow these and similar emotions intrude, contributing to elected distance and conscious disregard between nurses and midwives.

Empathy might be considered an imaginative extension of wonder and curiosity. I must be drawn to the individual experience of another in such a way that I question how I would feel if experiencing the same thing from the other's standpoint; as if 'standing in their shoes.' Although empathy is not essential to compassion, it can intensify and give added meaning to the emotion by "establishing concern and connection" (Nussbaum, 2003, p. 331). Nurses and midwives are in an excellent position to use their imaginations in empathy for one another because of their experiences of being with and caring for childbearing women and their babies. Both know the intense, one-pointed involvement of speaking softly into a labouring woman's ear to encourage her embodied work; or the joy and relief of receiving a vigorous, pink newborn into their hands. Both know the sickening feeling induced by the sound of a decelerating fetal heartbeat. We usually associate empathy with meaningful and sympathetic interaction; that is, relationally moral interaction. However, empathy is morally neutral. It can be used for the purposes of manipulation and harm as well as to enhance a compassionate response (Clark, 1997; Nussbaum, 2003). Yet when empathy is employed in my attempt to imagine another's experience it necessitates that I acknowledge her humanity, at least in substance, as like my humanity. At the same time, I acknowledge her alterity in my position as witness to the experience that is hers alone (Davies, 2003). The ability to empathize is facilitated by the detail of my knowledge of her as well as fellow feeling regarding all that I perceive us

to hold in common (Nussbaum, 2003). But the accuracy of my empathy can only be tested, if and when I communicate it, by the other's response. And so, the fulfillment of empathy is dialogic. Empathy opens the pathway to explore those ways in which we are different as well as our commonalities, but motivation to take this path requires a truly ethical turn in my regard for the other; that of respect.

Respect is part of the eudaimonistic judgment of another and closely linked with compassion. Bergum and Dossetor (2005) posit that our meanings for and expressions of respect can be distilled as follows: "the sense of *worth* or *worthiness* seems to be at the heart and core of contemporary notions of respect" (p.68). To acknowledge the worthiness of another gives them meaning and value in my experience and understanding of the world. At the same time, respect for another is evidence of my self-respect to the extent that I am worthy as an individual who views another as an end in themselves, not as a means to my ends. I acknowledge that another person, worthy of esteem, has affected me in a way that benefits my life. I accord the same value to them that I accord to myself. Although respect between people may or may not be mutual it is necessarily relational and ethical. It is my way of being towards another that implies that I honour them and wish to treat them with deference and consideration; I am committed to doing good toward them. Mutual respect occurs through engagement and dialogue, and a shared understanding of the value of ourselves and each other; recognition of one another's worthiness regardless of our differences. It enhances and focuses both empathy and compassion; and it goes beyond them in ethical relevance because it is always at its core positive regard. Through mutual respect our goals and ends can be brought more easily into synergy (Bergum & Dossetor, 2005; Taylor, 1991).

The participants in this study demonstrated some compunction to extend actions based in these relationally ethical ways of being to patients and clients. What is also needed is an intentional means of educing and recognizing these feelings between caregivers. The anecdotes in the Chapter Six seem to be largely devoid of mutual respect or compassion. Nurses' and midwives' apparent need to compare and differentiate themselves and their ways of being as caregivers can exacerbate competition and ambivalence. Empathy is little used except to imagine or project negative judgments, and so becomes a justification for alienation rather than recognition of connectedness. Each group takes a stance apart from the other, highlighting the distance between them. Having avoided proximity they may also be freed from the necessity of acknowledging one another's personhood and protected from the tug – moral or otherwise – that might lead them to explore one another's understanding and views. So, they may judge and appraise one another's practice according to the 'truth' of their own philosophical, paradigmatic, and social contexts. In this way they insulate themselves against those things that they hold and value in common, as well as against their differences.

What are the alternatives to the uncomfortable interactions between midwives and nurses explored in the previous chapter? Ongoing abrasiveness and entrenched assumptions regarding one another are exhausting, depersonalizing, and could lead for some to total avoidance and actual refusal to work together. Familiarity over time may bring some sense of predictability but does not necessarily mean increased trust, easy proximity, or revised appraisals of one another. The voices and anecdotes in this chapter show primarily the *inverse* of what it means to relate ethically, but in so doing they can evoke the desire for positive, healing possibilities. A few stories hold glimpses of a

tentative reaching towards collegiality, and some are even exemplars as to how the way forward might be sought.

Opting for Hierarchy

Power differentials are necessary in any system or relationship from time to time. When the exercise of power is used appropriately and seen as fluid, recognized in each relational member, it can be beneficial to the well-being of all of those implicated (Bergum & Dossetor, 2005). However, in an institutional social structure like the hospital, power can become the solidified privilege of a few and oppressive to others. As has already been highlighted, nurses are socialized into this hierarchy. They both accept their place in the system as the status quo, and chafe against it for the ways in which it is oppressive for them and their patients. An unfortunate result of this hierarchy is the horizontal violence that it sometimes motivates in those who seek for personal reasons to exert power and authority in negative ways over their peers. Horizontal violence is interpersonal violence and bullying between those of the same social position and includes behaviours such as verbal aggression, hostility, exclusion, withholding of information, unwarranted criticism, intimidation and humiliation in the presence of others (McKenna, Smith, Pool, & Coverdale, 2003). This is behaviour devoid of respect and compassion. As has been shown, some nurses may view midwives as like themselves, or assume that they should have the same status in the social structure, and therefore are essentially peers. In addition, nurses and midwives are women competing for authority, which, viewed through a feminist lens, can compound their potential feelings of interpersonal misogyny and oppression (Farrell, 2001). This combined with the fact that

midwives may be relative strangers in the hospital milieu makes them easy targets for this horizontal violence on the part of nurses. Midwives too may succumb to using power as a means of asserting their authority over nurses and as a defense, or in order to establish their place in the hierarchical social system. In the aggressive mire of power-over relations, the seeds of mutual respect cannot germinate.

Intimidating?

The setting for this account was a hospital labour and delivery room where midwife Judith's client was labouring with an epidural. The nurse was present to manage and monitor the epidural, and Judith was there as the primary caregiver and support for her client. Both were there in order to facilitate this woman in a safe and satisfying delivery of her baby. This is the midwife's story.

> Let me tell you about one time, it was probably about a year after we were legislated and were given hospital privileges. The hospital has a policy that once an epidural goes in a Foley catheter [urinary catheter] must be inserted. They won't let women try to pee on a bedpan and stuff. So the catheter goes in and it stays in. I was caring for a client who had an epidural and, of course, the nurse put in a Foley. I fought with a few nurses over this stupid catheter issue but I thought, I will let it go, I'll just let it go for now, but when she's fully dilated I'm going to take it out for the pushing. So my client gets to fully, and she gets pushing, and I go to take the catheter out. But the nurse says no, I'm not allowed to do it. And I thought, I'm not going to fight in front of the woman. I should have just said, "I'm taking the catheter out," but I didn't.

So anyway, the baby delivers, and afterward, the woman's whole vulva area was swollen, and she had these abrasions right where the catheter was. So I just said to the nurse, "Come here, I would like to just show you." And I said it in a very nice way, an educative way, "This is why I personally don't like to leave catheters in when women are pushing because, as you can see here, this is going to be very bothersome." And the nurse went *un-glued*, totally *unglued*! She left the room; she was in tears in the nurse manager's office saying that she would never ever work with midwives again. She said that I embarrassed her, and blah, blah, blah. And the Nurse Manager tried to get her to talk to me; no she wouldn't talk to me. Absolutely no. No. So, I mean I wouldn't have done it to be intimidating or anything like that. Fortunately my client was so involved with her baby that she never even knew this was going on. I did it very, very discreetly. (Judith, midwife)

In this anecdote, caregiver roles do not seem to be an issue of confusion or contention; however, the power and authority conferred by the roles are. In concrete terms, this unfortunate interaction occurred because the nurse clung rigidly to a unit policy and the midwife tried to avoid a confrontation in front of her client. Removal of a catheter, particularly in the second stage of labour, seems like a very small issue, something to be played according to the particularity of the situation and the labouring woman. It is typical for midwives to support their client in having little intervention and in keeping the process of birth as natural as possible. Despite use of an epidural for pain relief, the midwife's words imply that she did not think a urinary catheter was necessary.

The nurse became a part of this birth event because she was needed to manage the epidural and its technology, and was required to do this according to hospital policy. What caused the nurse to be rule-bound in this case? As the one responsible for nursing care related to an epidural and the charting in that regard, and as a hospital employee, a nurse can be expected to know that she is duty-bound to be accountable by following hospital policy. In this case, the nurse's unwillingness for the midwife to remove the catheter during the second stage of labour could have several explanations. For example, she may have believed that it was in the best interests of the labouring woman to leave the catheter in situ, and that her judgment in the situation was superior to the midwife's; that enforcement of policy was the safest practice. Or, she might have chosen to protect herself by following policy to the letter in case something untoward was to occur. The midwife's description shows the nurse as unwilling to violate the authority of what was 'allowed' in the situation; the 'rightness' of the hospital and its policies. Did the midwife need to be brought into conformity with the mores of the institution?

When the midwife pointed out to the nurse the minor damage done by the catheter, she says that the nurse "went unglued," was upset enough to be in tears. The statement brings to mind some rigidity or brittleness that does not hold. What caused this? Was it the fact that the midwife, a relative outsider, showed the nurse the evidence of her inadvertent misjudgment? Was the midwife's manner intimidating? Perhaps the nurse was deeply embarrassed at being betrayed by the rules that she sought to uphold. She followed the policy and yet the person whose welfare her action, the institution, and the rules are supposed to protect was injured. Do nurses, at times and unwittingly, cause harm to patients by following the rules? Perhaps the midwife's justification for removal

of the catheter in showing the nurse the woman's abrasions, and her attempt to be instructive in that regard was humiliating. Did the nurse feel her authority had been trumped? Whatever the nurse experienced in this situation, the midwife says it caused her to state that she would avoid working with midwives in the future. The midwife indicates that she acted, against her own better judgment, in the interests of preserving a non-confrontational atmosphere for her client. Might this also have preserved some semblance of collegiality with the nurse? Authority seems to have been at issue for the midwife, particularly as her concern for her client's wellbeing was validated. She suggests that she should have asserted her intention and followed through with it. Perhaps pointing out the damage done by the catheter was a small assertion of power.

One can imagine the midwife and the nurse beside and standing over the labouring woman: the nurse taking and recording blood pressures and the sensory level of the epidural block; and the midwife holding the woman's hand, talking with her, supporting her body and encouraging her to rest or push. Did the woman sense a prickling friction between her two caregivers, or stiffness in their interaction, a repellant insulation filling the space between them? She was at once central and peripheral to this situation. She and her welfare were ostensibly the focus. However, at the moments of conflict was the energy and attention of her caregivers sucked into the chasm between them making her the object of a power struggle?

Treating Them Like the Doctors Do

The midwife found this interaction significant enough to bring it to the nurse manager. At a meeting with her, the unit charge nurses, and other midwives who had privileges at the hospital, she raised it.

We talked about that situation at a meeting with the charge nurses and the nurse manager. The midwives get together with them two or three times a year to discuss any problems that come up. And so I raised this issue about the catheter and stuff. And, of course, the charge nurses were just black and white: "Well you're in charge of your client's care. You can order whether the catheter comes out or not. Just order it." And I go, "Oh, okay, I'll just treat them like the doctors do and just say it is coming out."

And so I have changed my approach a little bit. And if the nurse gets a little bit snippy, well, then I do; I just bark orders at them. And it's a shame because it's not my personality and I don't think that that's what we're about. We've intended midwives to sort of work on an equal basis with nurses. But it made me realize that there is a medical hierarchy and that's how nurses respond. And without a doubt, physicians are first and nurses think that they are second and that we are under them. But clearly, because we're primary care providers, we do have authority over the nurses. And that's how nurses respond. That's how they're trained, they're trained to take orders, I guess; and to be clear, to be clear. They believe everybody should have a clear role. But...I didn't anticipate this in the beginning, this hierarchy stuff. I thought, my communication skills with nurses were good, I sort of knew where they're at, that this would be all right. No, I wasn't expecting this at all. (Judith, midwife)

The charge nurses' response to the midwife's report of the catheter incident suggests a taken-for-granted understanding on their part that nurses in the hospital operate within a social structure built on power and authority that shapes and affects the

nature of interactions and the hierarchy of relationships. The collaborative practice literature shows this taking-for-granted of the health care system hierarchy is a major challenge to collegial relation (Hall, 2005; Stapleton, 1998). The charge nurses' words imply that the nurse stepped out of her place, or challenged the midwife's, by insisting that the labouring woman remain catheterized during the second stage of labour. They affirmed the acceptability of one professional asserting her authority over another. Such action maintains the classifications and identities that differentiate "socially assigned rights and duties" (Bauman, 1993, p. 120). Simply put, the midwife had the right to order what she wanted and should have been obeyed. Is this an appropriate use of power and authority? Bergum and Dossetor (2005) suggest that such an assertive use of power can only be appropriate where respectful relation is established. Otherwise, the inevitable result is a feeling of powerlessness and devaluation for the person over whom authority is exerted. "When relationship is absent, doing something technical is, at times, the only possible response." (Bergum & Dossetor, 2005, p. 95) For the nurse in this situation, maintaining control over the epidural and catheter as her means of providing 'good care' for the woman, may have provided her only source of esteem and power where a relation of mutual respect with the midwife and her client was absent or lacking.

The midwife grasps the assumption regarding hierarchy expressed by the charge nurses. As she was telling this story a note of sarcasm entered her voice when she said that she would behave towards nurses as a physicians do. Midwives describe their philosophy modus of care as women-centred. Nurses are women, just as their clients are. However, this midwife says that her intention and attempts to interact with nurses as equals are not received as she expected. She has judged at least some nurses incapable of

accepting the offer of collegiality, being inured to hierarchy, and so she has ceased to be collegial. In order to do her work in the social environment of the hospital she has chosen to respond to their 'snippiness,' rudeness or disrespect, with comparable discourtesy. Although she expresses disappointment at the necessity to relate in this way, she seems to accept it as unavoidable. Rather than standing outside of, or challenging, the hierarchy of the hospital, she asserts her place within it as superior to nurses.

Treating others with whom one must work or act with dominance and disrespect recognizes them only as the means to an end, rather than good ends, as persons, in themselves. Retaliation, distance, and defense are likely to flourish rather than empathy and compassion. This non-relation drastically limits the opportunity for the mutual knowledge and respect necessary for collegiality to grow. Is there a way in which midwives can advocate for and support their clients in the hospital setting without taking this hierarchical stance? Can they assert power and authority in their clients' care by means of power-with nurses rather than power-over them, allowing the true practices of nursing to show along side of their own? The destructive potential of power can be mitigated when grounded in a relation of mutual respect. Where mutual respect is present between caregivers, each person in the relation has power conferred by the acknowledgement not of their independent power, authority and status, but of their interdependence. Interdependence does not mean relinquishing the power that is integral to one's identity and role, but rather the dialogue and dance that seeks to draw strength from one another, enhancing all identities and roles together through a respectful reciprocity (Bergum & Dossetor, 2005).

In addition to the dynamics of power and authority shown in the midwife's story above, other aspects of relation and interaction between nurses and midwives are elucidated. In particular, the experience of alienation that nurses and midwives often undergo in one another's presence; the need to delineate fault and correctness; the rudeness used to bolster distance and differentiation; the taken-for-granted influence of external social structures on the epistemological shaping of knowledge called into use; and related to this, the defensive certainty that there is one right way to act in a given situation. All of these themes are negatively relevant to an understanding of ethical collegial relation, as other participants' accounts show.

Alienating

An alien is a foreigner from another country or another world; someone who belongs to someplace other than where I am at home; a place with relevances different from my own. Aliens are often easily recognized as strangers and may name, value and ascribe meanings to common phenomena that are different from those understood by me and the 'in-group' of my local, prevailing society or culture (Shutz, 1964a, 1970). In contrast to the alien stranger, Schutz (1964a) suggests that this in-group functions by a shared system of knowledge that supplies its members with "a *sufficient* coherence, clarity, and consistency to give anybody [in the group] a reasonable chance of understanding and of being understood"; that is, a "thinking-as-usual" based on common assumptions (p. 95-96). The stranger in our midst is not a transitory tourist or visitor, but rather someone who, due to whatever exigency, wishes or needs to be assimilated, or at least socially adjusted, to the life-world of the in-group. This individual must question

most things around her and may be in a constant state of crisis because she does not know the 'thinking-as-usual' patterns or the foreign (to her) topography on the in-group's map of relevances. All she has for guidance are the reference points and assumptions common to her own place and people by which to interpret this new society in which she is immersed. Hall (2005) describes the 'boundary-work' of in-group mentality, that is exclusive differentiation and cultivation of professional epistemologies and referents, as a means by which professions strengthen their ideology and worldview. The effect of this boundary-work is that it may be the basis for assessing other professions as 'other,' fraudulent and less competent.

Nurses and midwives can be considered, to a significant degree, foreigners, aliens, or strangers in one another's presence, particularly within the context of shared care for midwives' clients in the hospital. A midwife may be more or less familiar and comfortable with the hospital environment and the 'thinking-as-usual' of the nurses. In the case of a midwife with a nursing background, she may adjust and be able to take these into consideration more easily. Yet, as several of the study participants described in describing the history of their professional choice, because she identifies as a midwife, not a nurse, there has been a fundamental shift in her sense of self, her assumptions, and ways of working with childbearing women. This inevitably leads to comparison and a desire to clarify the ways in which her experiences and thinking as a midwife differ from nurses'. Such a midwife returns to what once might have been a kind of 'home', but brings with her as new set of relevances. Nurses, as a group, are no longer members of her primary set and so may be relegated to a stereotype, their ways of being understood through the lens of typification (Schutz, 1964b). It is as if she might say, 'I know who

you are, because I was one of you, but I am different – better, perhaps – now.' For those who began primarily as homebirth midwives and have no nursing education, the hospital milieu may indeed cause them to feel like outsiders. However, it is possible that as true strangers to nurses' ways some may be more open, or at least more neutral, in response when collaborating with nurses because they have a less urgent, personally historical need to assert their differences.

For most hospital-based perinatal nurses, the society of community-based midwives is unknown territory, a place where their "system of relevances" is overthrown and where they may find themselves in "a crisis" because "thinking-as-usual becomes unworkable" (Shutz, 1964a, p. 96). This may be especially the case when alone in a room with a midwife and her client, as illustrated by nurse Jenna's experience of being the "third wheel," the "bad medical person," or nurse Vivian's description of being "stuck in the middle." As Bauman (1993) says, "The 'strangeness' of strangers means precisely our feeling of being lost, of not knowing how to act and what to expect, and the resulting unwillingness of engagement" (p.149). Outside of the drawn curtain or closed door of the labour room, in the company of other nurses, a nurse may be able to assert her sense of place as a member of an 'in-group.' Here she has the comfort of camaraderie in which she is able to feel a "pre-packaged" reciprocity of understanding (Bauman, 1993, p. 147). From this vantage it is easier to distance midwives, to tolerate them, perhaps, but remain largely dissociated from them. Although such a default position provides the comfort of familiarity, it is not collegial to those outside her group, does little to inspire empathy for the midwife's possible feelings of isolation, or to consider how to address them with

compassion. Nor does it provide the possibility for proximity and dialogue that might allow mutual respect to grow.

Dealing with the Odds

Alison, a perinatal nurse, speaks of some of the reasons why a local midwife seems strange and alien to her and her nursing co-workers. The alterity with which the midwife is regarded and the social distance at which she is held are evident in Alison's words.

> Another thing about which we've been very concerned – only in the respect that we should be aware – the midwife does give her patients herbal things. And we don't know what they are; she won't tell us. And when they are in labour and it's something that's going in that patient's mouth, it should be documented on the chart, as far as I'm concerned. Some herbal things do affect people. That was an issue that was supposed to be talked about at one of the meetings. It came to a head a couple of months ago. So we have to get things sorted out. But she gave her patient some potion to drink or something. And that's not to say that the woman can't have it; just, what is it? Document it and then we could learn. Some herbal substances are anticoagulants and others could affect you if you have an anesthetic. But no, I didn't see anything documented on the chart. One of the nurses was very concerned because she saw the midwife give the patient something and she said, "What is it?" And the midwife said, "Oh just a little something. It will help her." But if it's not a big deal, then why not say what it is? And also, if you want to teach, then give us something to learn. But it seems to be this tight-lipped stuff. And like I say, I don't know if she feels she can't tell us, or

she's getting vibes that make her not want to tell us, or whatever. There is a personality conflict for sure there. It seems like she comes with a chip on her shoulder, because she knows that she is dealing with the odds already, I think. (Alison, perinatal nurse)

'Odd' and 'odds' are two words the meanings of which have relevance here. *Odd* indicates difference, something out of the ordinary or peculiar; also, evidence of unevenness or inequality. '*Odds*' is closely related, commonly meaning the probability of one thing over another (again, unevenness and difference); or disagreement, conflict, as in 'being at odds' (Simpson, et al., 1989). Phenomena that seem to be identified as odd in this narrative are herbal remedies, the midwife's conduct, and, perhaps, the midwife herself as implied by the suggestion that the nurses are at odds with her, and that the odds of her being accepted by them are minimal. Herbal remedies are not among the therapeutic options available to nurses in their care for women in the hospital; in addition, they would not normally be considered or prescribed by the physicians whose orders for pharmacotherapy nurses carry out. Moreover, the word, "potion", immediately brings to mind quackery or witchcraft, casting aspersions on both the substance and the midwife who administers it. In the context and practice of North American mainstream medicine, herbal remedies are somewhat foreign, associated with the old world and with less scientifically enlightened practices. The nurse's description of the use of herbs or naturopathic substances by the midwife seems symbolic of a constellation of significant differences that set the midwife apart from her and her co-workers. As an alien among them, the midwife brought what are viewed as foreign ways and beliefs regarding birth and what may be efficacious. As an outsider not only her approaches, but also she herself

was suspect; perhaps considered untrustworthy because she withheld information, and differently educated, or naïve, because she drew on unconventional knowledge.

The midwife's reluctance to identify the substances she used or to chart them was an oddity. Within the hospital and the medicolegal system at-large the status, care, and treatment of patients must be clearly and parsimoniously documented. Throughout British Columbia a standard set of records are used for the antepartum, intrapartum, and postpartum periods by the woman's and her newborn's caregivers. Midwives, physicians, and nurses use the same set of forms for each individual woman, and so, nurse Alison or her co-workers would have had access to this midwife's client's paperwork while she was in hospital (British Columbia Reproductive Care Program, 1998). In this regard, it was odd and concerning to the nurses that the midwife did not chart what she gave her client, and perhaps more odd and concerning that she was evasive when asked about what she was giving. Was she hiding something? Would the information she withheld be judged by the nurses as arcane or ridiculous? The nurse's assertion that she and her co-workers should know what has been given is justified in the interests of safety. Was the midwife's action, in fact, unsafe? Although the nurse telling of this situation suggests that she and her fellows might learn something from the midwife, would they offer her that credibility? Collegial exchange might be difficult if the midwife has been deemed to be difficult, defensive, and different.

Difference is predicated on an ontological understanding of the world that separates me from you as subject from object. The ontological assumptions of modernity place me, as the subject, in a solipsistic frame that inevitably causes me to evaluate you and others as either like or unlike me, alien or the same. Along with this appraisal may

come judgments regarding your worth as compared to mine based on many and various criteria. I may accept you, if similar enough, to share a central place with me; or, if sufficiently or uncomfortably foreign, may attempt to exclude you, relegate you to the margins (Olthuis, 2000). Olthuis (2000) suggests that liberal moderns seek to overcome exclusion by extending the boundaries of the centre to include different others; by being tolerant. I may endeavour to equate the status of others with mine in this way, but still avoid examining, dialoguing and negotiating, the significance of our differences. Although a postmodern understanding of difference acknowledges the existence of the multiple centres and margins of many identity narratives rather than the primacy of a monolithic meta-narrative, the delineations of self and other, our levels of privilege and power continue. The boundaries between different circles of significance remain largely unexplored, impenetrable and can become even more powerfully entrenched sources of alienation (Olthuis, 2000).

As Bauman (2003) and others (e.g. Davies, 2001; Olthuis, 2000) propose, Western culture (including its healthcare systems and professions) is shaped by the 'facts' of this ontology that conceives of the world in terms of the identities and the narratives of separate beings, which dictate the modes by which beings interact. The nurse's account above about the midwife's alterity, her oddness, illustrates this in the ways in which both the midwife's actions and the nurses purported attitudes, which tacitly acknowledge and highlight the fact of differences between them, contribute to the midwife's marginalization. Although in her speculation the nurse makes a feeble stab at empathy, she seems ultimately to blame the midwife for her own ostracism. How might a the

openness of ethical relation mitigate this estrangement, this difference without relation between persons and ways of being?

Levinas (1985) calls us to consider that, rather than ontology, the philosophy of being that comprehends the world through a system of identities, "First philosophy is an ethics" (p.77). An ethics that comes before ontology, and so does not let ontological presumptions and divisions interfere with relation (Bauman, 2003). This 'first philosophy' is the face-to-face relation (Levinas, 1985) between another and myself that "is not a matter of thinking the ego and the other together" (p. 77) within shared present and separate past contexts, but rather it is my response to the "signification without context" (p. 86) of the other's 'face.' She stands before me as herself, "uncontainable," beyond my knowledge (p. 87). She is a question and speaks to me from her mystery; so, my ethical call is to response. Dialogue (response-ibility) is the praxis of such an ethics (Levinas, 1985). In my response – responsibility – toward her I affirm her worth without labels, without judgment. However, as acknowledged above, we live in an ontologically understood world. How do nurses and midwives, step out of this circumscription in relation? It is through dialogue, which calls for respect toward the other as first impulse. If relation begins from this place outside of and before ontological assumptions, it begins from the proximity and openness of face-to-face. From this place the weaving of a collegial, interprofessional way of working can begin.

In the situation described by nurse Alison, an initial attitude of welcome and response, respect, on the part of the nurses toward the midwife might have diminished her guardedness and opened her in turn to welcome, or at least not seek to avoid, the nurses' inquiries and to confidently communicate her actions. This would have shown a

respectful response toward the nurses, acknowledging their obligation to know what care and treatment patients receive that might affect them, physiologically or otherwise. Instead the quality of the interaction described between the nurses and midwife may actually strengthen the impermeability of their difference and distance from one another.

Policing

Sheila, a midwife, tells of a situation where she and her client were subject to officious and impatient behaviour by nurses who seemed to view them as uncomfortably alien and unruly in their requests for information and individual consideration. In this case both the midwife and her client disrupt the taken-for-granted running of affairs with their insistence and unwillingness to accept the status quo.

> I had a client who was 32 weeks gestation with ruptured membranes. Because of this we had to do a transfer of care to an obstetrician at an institution, but I could still do supportive care. So she went to the hospital to have IV antibiotics and I went with her. The nurses were very annoyed with her because she held them up by questioning them. She wouldn't let them start the IV until she knew more about what they were going to give her. She asked, "Why are you giving this to me? Can I make a decision?" And I said to the nurses, "Give the woman the information and then she can make the decision about whether she wants this. But she can't just hear you, put this information through her head, and give you an answer straight away. She feels that you are getting at her. Please let her make the decision. We have got time."
>
> This client also had an ultrasound and she wanted to know what the result was. So I took the ultrasound report from the nursing station and brought it to her

so we could look at it and talk about it together. I went back to the desk and the nurse said to me, "Sheila, you are out of line. Don't you realize that the doctor will talk to the patient about this ultrasound report?" I said, "Well this piece of paper is the patient's paper, it's not your paper, this is a communication tool." She was very very angry with me. I said, "The patient has a right to look at her notes." And she said, "No, she hasn't!" I said, "Yes, she has!" And I walked away thinking, 'you can do what you like; go ahead, report me.' And then I turned around and laughed. I said, "Are you the midwifery police?" She said, "Well, I'm going to talk to the head nurse." I said, "Fine, but this patient has every right to look at her notes when she likes and how she likes." "Oh," she said, "She has to sign the form." I said, "She is in the hospital, she doesn't have to sign any forms." "It's not your duty, Sheila." And I said, "It *is* my duty. I can give supportive care." So here we were arguing. The nurse was quite happy to let the doctor do the doctor thing, show my client the notes, but resented me saying, let the woman look at her notes. (Sheila, midwife)

To police is to control, regulate, keep in order (Simpson, et al., 1989). Who or what requires policing? Criminals, political radicals, illegal aliens and disturbers of the peace come to mind. Is Sheila justified in her sardonic question of the nurse? If so, what about Sheila and her client in particular was so disquieting? It seems that they did disturb the peace of the unit, and perhaps were regarded as unwelcome, if not illegal, aliens. They were also 'politically radical' in the sense that they caused a temporary rupture in the polity of the hospital unit. Sheila and her client showed themselves to be intruders into the structured sociality of nurses and physicians within the hospital unit, by

demonstrating unwillingness to abide by the conventions that regulate it as a social space. They came as outsiders who could not be ignored, both because of the professional commitment of the nurses, and because of their unruliness, which demanded notice and response. They did not behave as compliant and semi-anonymous patient and patient support-person who might acquiesce to the perfunctory authority of the nurses.

The conflict between the midwife and the nurse in this anecdote was over the ownership of specific information, and the right to use specific knowledge to interpret that information. Orders had come down from the physician through the nurses to be administered in the conventional way to the woman. The midwife's client wanted to know about the antibiotic and to exercise choice in deciding whether to receive it. That is, she wanted to interpret the information in terms of her own personal relevances. Who was this woman to question the order? After all, it is often the case that patients receive medication or treatment prescribed by a physician unquestioningly or with minimal understanding through the administering nurse because they trust in or are willing to acquiesce to her professional authority and the assumptions of the context.

Likewise, the nurse at the desk demonstrated the premise that the knowledge required to interpret an ultrasound report was the physician's to own; the physician alone was authorized to translate the mysterious code for the woman. Did she see the midwife as an interloper, exerting authority that was not rightfully hers? She also exhibited the presupposition that the piece of paper, the report itself, belonged to the physician (just as the woman 'belonged' to the physician as a patient) or at least to the hospital record-keeping system. The idea that the woman herself had primary ownership of the report and could derive her own meaning from it with support from the midwife was not willingly

considered. As in other participant anecdotes, there was a power struggle played out between the nurse and midwife. In this the nurse was an insider and gatekeeper who knew and righteously upheld the thinking-as-usual of the hospital, while the midwife and her client were positioned as outsiders.

Both perinatal nurses and midwives ascribe to a philosophy of patient- or client-centred care as a part of their professional ethical comportment toward patients and clients. Midwives quite consciously and specifically may refer to this care as 'woman-centred,' whereas perinatal nurses often speak of it as 'family-centred.' Although the implications of such care would appear to be very similar, the ways in which the care is enacted may be quite different, due in part to differences in philosophy and the location where the majority of care occurs. As has already been described, most care by midwives is given in homes and clinics; non-institutional settings that can more easily allow for the needs and wishes of individual women to be accommodated and where children and family members generally can be present without concern for infection and the disturbance of other's activities and routines. Perinatal nurses who give care in a hospital environment have an obligation and loyalty to the institution and its social structure. Institutional restrictions, although they vary from place to place, seek to preserve not only a clean, calm and efficient environment, but also to accommodate those who work there through established regimens and limiting the presence of outsiders. So, although the perinatal philosophy of a hospital may be patient- and family-centred, this is enacted and circumscribed within a system that accommodates the institution. Nurses' patients spend intense, life-changing, but brief time with them and only in the hospital context, and then they sink back into the world of anonymous strangers. Patients' relative anonymity

combined with the precedence and habitual obligation given to the policies, rules and conventions of the institution can, at times, cause nurses to forget the quality of individual women's experiences. This may be particularly the case with midwives' clients.

These women enter the hospital as alien, having chosen complete care by midwives rather than physicians and nurses. They are admitted as 'patients,' but nurses may assume that they are precluded from developing mutually meaningful relationships with these women, however brief, because of the intense and all-encompassing nature of the midwife-client relation. Such an assumption can leave nurses with little interactive function other than that of, technician, as shown in previous stories, or gatekeeper and guard of the life of the institution. It was this gate-keeping role that placed the nurses in midwife Sheila's anecdote at odds with the midwife. As outsiders to the hospital the midwife and her client had little to distract them from their focus on the woman's needs and concerns. The midwife did not demonstrate conflicting obligations to the institution which would have kept her from insisting on woman-centred care. The nurses' response was to police, control and protect the symbols of privileged knowledge, such as the ultrasound report, and the distinct roles and functions of those who make up the social order. This seems to have superseded their advocatory patient- and family-centred approach. Did the nurses forget empathy and compassion for this woman facing a pregnancy complication?

The weapons used in this conflict were antagonism and ungracious behaviour including blatant rudeness, as was demonstrated in the exchange between the midwife and the nurse at the desk. Would the midwife and the nurse have behaved as they did had

they viewed one another as colleagues; or even as guest (the midwife) and host (the nurses)? Hospitality to strangers follows from an ethics of respect and assumes that the guest or stranger is a friend. In this case, the midwife and her client do not seem to have been viewed positively, much less as friends. The result was an adversarial struggle in which alienation between the nurses and midwife contributed to the overt hostility.

Scapegoating

Both nurses and midwives spoke of how blame was either unjustly laid on them, or of how it belonged with the other. In most cases the anecdotes reveal a need to exculpate or justify the narrator in order to show that the other was responsible for incompetence, a dangerous situation, or the childbearing woman's unhappiness and disappointment with events. However, occasionally the midwife's client becomes the scapegoat against whom violence is spoken. What is the felt impulse behind this need to target blame? What is the experience of being identified as the scapegoat?

The scapegoat has its origin in ancient Mosaic Law where on the Day of Atonement two goats were selected to enact a doubly potent ritual of redemption and propitiation (Simpson, et al., 1989). One was sent out into the wilderness to wander to an irrevocable distance far from the community symbolically bearing the sins of the people. The other was sacrificed on the altar of Yahweh, allowing the community to witness the annihilation of 'the sinner among them' by proxy. By this rite the people were freed from fear, cleansed from sin, reestablished in a right relationship with God and one another. Girard (1977) claims that this practice of scapegoating in order to cleanse a community or tribe of some evil, sickness or internal antipathy has been prevalent in many cultures and

societies, and that expressions of it recur throughout history in mythology, religious texts, works of art, literature and drama. Even in contemporary times a common cause against an alien, rival or enemy is, in some form, an inevitable and periodic strategy of human societies in order to reestablish unity and bring a sense of safety and moral rectitude. According to Girard (1977) and Kearney (1999), the scapegoat or one selected to bear the sins of the many was often different in some identifiable way, and in particular, alien to members of the community. However, this person (or animal) was also enough like the group members to serve as a substitute; and so to take with it to death or distance the negative element that was their own but could not, for the sake of intra-group peace, be identified with one of their own. "The sacrificial scapegoat is the one who [...] enabled the internally divided society to turn away from its own internecine rivalry and focus its hatred on someone from *outside* the tribe" (Kearney, 1999, p. 252).

Over time the term, scapegoat, has come to mean the one who is blamed or punished, as well as the one who, at one time, was ritually murdered for the sins committed by others (Simpson, et al., 1989). When rivalry arises between people or groups we do not, except in the case of war or juridical punishment, murder one another to reestablish balance. Nor are blame and punishment associated with the sacred, except in the context of institutionalized religion. Rather we often find it easy to allay our fears and anxieties by treating those who inspire them with disrespect and disregard, keeping them at an emotional or territorial distance. We deal with threat and rivalry through a keen and biased appraisal of the other, seeking out and highlighting any real or suspected fault and failure in those who arouse these feelings in us.

Deborah, a perinatal nurse, tells a story that illustrates this experience of distancing and blaming; being 'scapegoated.'

> There are a couple [of midwives] I prefer not to work with because their skills are not...it's a dangerous situation. They do things that are not medically safe and they don't allow people to know about it. What sometimes happens is that when I come into the room I see that this isn't safe and that isn't safe. But, if anything goes wrong, "It's not my fault," says the midwife, "It's you. You are the nurse." And that makes it really uncomfortable. And if things go untoward some of them will also say to their clients that it's the nurse's fault. It just reinforces that, 'I never should have come to the hospital. I should have had the baby at home. It's because of the nurse that I had the [caesarean] section.' (Deborah, perinatal nurse)

This nurse begins her account with comments that reveal a clear sense of mistrust toward some of the midwives she encounters. She speaks with certainty that what some midwives do lies outside of the parameters of safety. In addition, by equating their skill with danger she suggests that these midwives may not be competent. She completes the picture by impugning them for lack of accountability. When things do not go smoothly, she says they blame nurses for what occurs. As she describes it, nurses are scapegoated by these midwives and perhaps even by their clients. In describing her interaction with some midwives in this way, the nurse seems to show what Schutz (1964a, 1964c) refers to as the looking-glass effect. That is, she may be substantiating by her own words a conviction that a prejudice against nurses exists, that these midwives, and perhaps their clients, stereotype nurses as interfering and medically interventive. However, her

comments could also be understood to have a certain vindictive quality, returning the blame. She continues with a specific example of such an interaction.

> A couple of months ago one of the midwives, the one that I would say is the least forthcoming in everything and anything, was in with a client. I went in just to see how her lady was getting along because I was free at the time. I'd had a delivery and the nurse that was initially assigned to the midwife was now involved with another patient. So I went in because I heard that this lady was fully and I wanted to see how they were doing. And the midwife had her lady on the monitor and she had been on the monitor for maybe a good half an hour, maybe a little longer. But the fetal heart rate was down to eighty, and had been at eighty for a while! The midwife was giving her oxygen, had her on her side and pushing but she didn't have an IV. The midwife hadn't rung for any help, hadn't consulted, hadn't called anybody. There she was, by herself! The baby was obviously distressed; *more* than distressed! I mean, the fetal heart tracing showed a little variability at the start, and now it was drifting down below eighty at a straight line[9]. "And when exactly were you planning on calling us?" I mean, I didn't say that; this is what you think afterward, but at the time all you do is react. You know, I called for help, got the IV going, called the obstetrician. The lady wasn't really fully dilated and the baby's head was not coming down. And so we rushed for an emergency section.

[9] A normal full-term fetal heartrate is from 110 to 160 beats per minute. Another sign of fetal wellbeing is evidence of variability in the heartbeat that appears as a zigzagging line with specific characteristics on a fetal monitor tracing. Given these parameters, a sustained fetal heartrate of 80 beats per minute is cause for concern and immediate intervention, as is a fetal heart tracing showing a relatively straight line, evidence of little or no variability.

Then, after the section, in the recovery room, you know, the lady was doing well, everything was fine. I was getting things organized. I was going to give her a post-op wash and that kind of stuff, because the midwives don't have recovery room skills; just trying to do the things that needed to be done. But the lady was the midwife's client and I was trying to leave them alone together, and so had the curtains closed. Then I heard the midwife saying from behind the curtain, "You know, I think if we'd just left you a little bit longer things might have been okay." And I just wanted to go, "Aaahhkkk!! I've got to get out; get out now!" Anyhow, so again, it's us versus them... (Deborah, perinatal nurse)

In this anecdote the nurse indicates that this particular midwife had not communicated an emergent situation to the nursing staff and in this isolated herself and her client from those who could have provided help. Whatever the cause for this reluctance to involve the nurses, her client's baby was put at risk. As the nurse describes the situation, the outrage she expresses at the midwife's behaviour seems justified. Why did she not call for help to rectify the situation of fetal distress? The incompetence of some midwives that the nurse alludes to in her first remarks is substantiated by not only the failure to act or call for help, but also in having the woman push against a not fully dilated cervix. In contrast, the nurse's reaction to the situation of fetal distress shows an immediate knowing, understanding, and acting typical of an experienced hospital-based nurse who is at home in the context and has witnessed such situations many times before (MacLeod, 1996). Might the familiarity or strangeness of the context, its allegiances and ethos, explain some of the differences in the midwife's and nurse's understandings of this situation and how it should be handled?

After the caesarean section the nurse provides post-operative nursing care to the midwife's client, something she says the midwife cannot do. She describes a moment when they are in the room together; the midwife is with her client behind a curtain that, no doubt, surrounds the bed on which the woman has been brought from the operating room. She overhears the midwife saying words to her client that in essence nullify everything the nurse has done; her assessment, judgment of a high risk situation and life-saving actions. The nurse hears this as adversarial and it impels her to remove herself as quickly as possible from any proximity to them. What did she feel in that moment? Moral indignation, anger, or betrayal? Was the discretion of choosing distance between them the only solution? Perhaps at that moment it was. But what about later, could a debriefing conversation have brought some understanding and collegiality to their interaction? Or would the need for disassociation be too strong?

The comparison between herself and the midwife in this nurse's account indicates a need to give evidence of the superiority of one over the other, an implication of competition, justification or rivalry. In this case the source was the provision of safe care, within two different understandings, in the birth of the midwife's client's baby. A rival is often someone who is an equal and whose objectives are the same. Rivalry is a competition between two or more to better or out perform one another with the assumption that the one proven to be the best at achieving the common goal is superior (Simpson, et al., 1989). Rivalry is adversarial. If I can convincingly attribute to my rival any faults, mistakes or failings in achieving the goal, then, even if we are apparently working together, I can make myself appear more worthy, more careful, more knowledgeable, more adept, etc. Rivalry has no place in ethical interprofessional

collegiality. Colleagues may challenge, motivate and inspire one another, and they may disagree, but these behaviours are not essentially adversarial nor are they necessarily done to increase one person's status over another. In addition, they are dialogic in nature. The nurse and midwife in this account relied on showing one another to be at fault, blaming and scapegoating each other. One can sympathize with the nurse's choice to distance herself in order to diffuse her feelings; but the ground between herself and the midwife was not recovered in order to open a dialogue regarding their concerns. Instead the story is related in retrospect with no hint of mutual respect.

That Nurse Flipped it Around

Midwife Val describes an experience of being scapegoated by a nurse that succeeded in undermining her confidence and authority, diminishing the collegiality that she initially assumed to be present in the situation.

> I had a birth a few months ago where there was thick meconium in the amniotic fluid. My client went really quickly so I called the paediatrician stat. The nurse was there for us, she knew there was meconium. I was the second, because Dianne [the conditional registrant] was delivering this baby. So, there are two midwives and a nurse in the room. The pediatrician runs in just as the baby is being suctioned on the perineum. So now we've got a nurse and a pediatrician at the isolette [radiant warmer and baby bed with attached resuscitation equipment]. There should be no question about who was doing what. The baby is handed immediately to the pediatrician by me. Two people at the isolette, so I stood back and went to help Dianne, because I thought this is fine. But after the birth the nurse grabs me and she says, "Your suction wasn't hooked up right." And I go

"What!??" She says, "Your suction wasn't hooked up right." And I said, "It was! I checked it, it was working fine." And she said, "Well, there was a problem with the suction."

So then later the pediatrician grabs me and says, "Val!" And I said, "What happened in there? I'm sorry if I hooked up the suction wrong." He said, "The suction was working fine. You checked it, I checked it. It was fine. The nurse didn't know what she was supposed to do! She didn't even block the hole on the meconium aspirator! The suction was working fine. But I'm really mad!" And I said, "Are you mad at me?" And he said, "No, it's not your fault. I'm just venting. You are an NRP [Neonatal Resuscitation Program] instructor, you run our NRP program; this is what I need you to do. I want you to go back and train all the nurses again because they don't know what to do." He said, "I suctioned the baby visually, and then I intubated and put the meconium aspirator on, and she [the nurse] is supposed to pull it out and she didn't pull it out. She tried to hook it up backwards, and then when she did hook it up properly she didn't put her thumb over the hole[10]." He said, "I abandoned it; the baby didn't get suctioned well enough because she didn't assist me properly."

The pediatrician admitted the baby to SCN too, because he was worried enough about it that he wanted it observed. He was concerned that he hadn't aspirated all the meconium because he saw some on the vocal cords. I think that's

[10] A meconium aspirator is a type of endotracheal tube that can be attached to a suction catheter. It is vented in order to control the suction manually. When the suction catheter is attached to the aspirator following intubation, blocking the vent will create suction so that the baby's airway can be cleared of meconium as the aspirator is gently removed. This maneuver takes two people, someone to intubate with the aspirator and stabilize it while the other person attaches the suction catheter, blocks the vent, and then slowly pulls the aspirator out.

what agitated him the most, he visualized the cords and he saw stuff there, and he wasn't able to get it out because the nurse didn't know how to assist him. And then, that nurse flipped it around and said that *I* didn't put the suction on right! So at first I was mortified because I thought I had done something wrong. I had been up all night and I couldn't really remember; it was one of those moments when you go... I mean I checked the suction, I *always* check the suction. Then I wondered, did I think I did it, and didn't do it? Like I had all these thoughts running through my head, and so, until I talked to the pediatrician, which was an hour after the fact, I was just going, 'oh shit!' But the nurse was very quick to lay it at my feet and I was so mortified that I accepted it. Here I am, an NRP instructor, and now she might go around telling people that I didn't set the suction up properly. (Val, midwife)

The emotions that the midwife experienced in this anecdote are clearly expressed. Initially she is confident that events will go smoothly, as all the key players are in place. She assumes that they know their roles and have the skills and knowledge to carry them out. Her shock and perplexity on being told that the suction on the isolette was not properly set up are evidence of genuine surprise and concern. After all, malfunctioning suction could greatly magnify the risk of meconium aspiration with serious sequelae for the baby. The midwife responds to the nurse with certainty and indignation but quickly moves to worry and self-doubt. If the nurse's intent was to lay guilt on the midwife for her own uncertainty and incompetence, it seems that she was partially successful.

What in the nurse's experience prompted her to do this? As the 'baby nurse' it was her responsibility to check the equipment herself before it was needed. Perhaps in the

situation she was embarrassed and worried about potential serious repercussions caused by her failed ability to assist the pediatrician, and so moved quickly to shield herself by laying accountability with someone else. Why was the midwife the scapegoat and not the physician? Was it because the midwife is more 'other' than either physician or nurse?

The midwife's words indicate that after speaking with the pediatrician she was relieved to know that she was not culpable for endangering the baby, but indignant at the nurse's accusation and ultimately worried for her own reputation. As the hospital's NRP instructor she must supervise the training of all the perinatal nurses in neonatal resuscitation techniques. The nurse's accusation succeeded in worrying the midwife and potentially tarnishing her reputation first by attributing responsibility for the equipment malfunction to her, and then, obliquely, as one of the midwife's trainees who failed to master life-saving skills.

The fact that participants related such stories of blame and rivalry speaks of an underlying state of crisis for both nurses and midwives caused by the interface of their members in the hospital setting. Midwives, as a newly recognized and legitimated profession, seem generally to be very conscious of their identification as outsiders – or, at least, untested newcomers – in the hospital milieu. All of the midwife participants in this study showed themselves to be assertive and relatively self-confident in the mission of midwifery. And all of them voluntarily engaged in some degree of informal public relations work to educate nurses and physicians regarding what they do and to clarify their expectations regarding practice with other health care providers. However, they have entered the place where nurses are at home, ostensibly as peers, but not really as equals. Midwives, of necessity, give orders to nurses and require their support, usually

without supporting the work of nurses in return. Some are more consultative in this than others. Nevertheless, the taken-for-granted-ness of this power differential is fodder for conflict and unethical relation.

When nurses seek to assert or affirm the value of their place by demonstrating their comfort with, or defense of, the habits, processes and rules of the hospital, midwives may judge or accuse them of pettiness and intransigence. Likewise, a nurse who is confused as to her role, or intimidated by a midwife, may be seen simply as unthinking or obstinate. Just as nurses seem to hold assumptions and expectations of midwives, so midwives may have the same kind of group-held expectations of nurses. A number of the stories in Chapter Five demonstrate this. Many of the midwives spoke in the third person about their experiences. This might be attributable to the fact that some of these participants work in group practices and were speaking of opinions held by their midwife partners as well as themselves. However, this voice also may have been used in our conversations because of solidarity among midwives specifically regarding common frustrations and difficulties in their work with nurses.

Nurses interacting with midwives may experience unexpected and confusing shifts in the chain of authority. Some nurses feel that they have been displaced and made redundant; that what they offer and do well is discounted. What may be most disturbing for them in this is that midwives are very like themselves, yet many are differently educated and all often work within a model of practice based on a philosophy and assumptions that seem foreign, unconventional or misguided to nurses. This can make midwives, at times, an irresistible target of criticism and blame. From the perspective of a perinatal nurse it would be easy to say that a midwife acts in a way that approximates

what a nurse would do, but that she does it incorrectly or with inattention to the 'right things' or to safety. Such accusations are likely to generate support and solidarity from other nurses because they reinforce the sense of rightness in the knowledge and skills, conventions and protocols, by which nurses perform their role. This could serve, at times, to eclipse the differences and rivalries among themselves, serving the precise purpose of the midwife as sacrificial scapegoat.

If blame and rivalry, condemnation and disregard toward others can create exclusive solidarity, at some unacknowledged level they can also obviate and perpetuate fear and threat of horizontal violence – of being scapegoated by one's own group. Having a scapegoat who is other than 'us' is, in the end, a false insurance. How might rivalry, projection of blame, and ostracism of difference be redeemed in relation? What is required to radicalize these reactions, to 'flip them around' differently, to invert and explore their opposite meanings and behaviours? Rivalry might be replaced with mutual assistance; blame with instruction and encouragement, or praise; and ostracism with openness and inclusion. For this to occur, if I am beyond feeling Levinas's pre-ontological moral response (Bauman, 1993), if I am hooked by the impulse to compete, accuse and distance, I must intentionally relinquish these self-protective behaviours and operate from a place of accountability and responsibility toward others. Caregiver codes of ethics ask us to do no less towards those of our own profession as well as those others we encounter in our professional capacity, whether caregivers or clients/patients. This is not easy and calls for honesty, self-examination and self-respect as well as respectful and compassionate regard for others. By taking conscious action in this way for personal growth and responsibility toward others, I may find that my ability to see others for who

they are, without labels, stripped of the assumptions I encase them in, becomes easier. I may find that I am transformed by ethical relation.

That Nurse has a Problem

In this anecdote, midwife Deanna describes the most disturbing, and perhaps dangerous, aspect of the evident rivalry between nurses and midwives. That is, when the childbearing woman becomes the scapegoat.

> I had one young woman it was her first baby. However, she had – I can't even remember the number of therapeutic abortions – between two and four. I went on a break, and when I came back she was very upset. Apparently the nurse who relieved me had taken it upon herself to do some 'counselling,' saying, "Were you raped? I see that you had these abortions. Why did you have these abortions?" She was in there for half an hour while I was gone. And I don't know what she thought she was going to do with that information. It didn't matter why my client had her abortions; especially at that time, when she was in labour. It brought up all kinds of stuff for her, and after that she didn't want *that* nurse or *any* of the nurses in the room. But then, what are we supposed to do? We can't do it all by ourselves. We need these people [nurses] to work with us, to support us. But that particular nurse has a problem. (Deanna, midwife)

What might have compelled this nurse to distress a labouring woman regarding her past? Was it cruelty or spite? Was it an attempt to assert power over the woman? Perhaps she wished to assure herself that this woman, a midwife's client and so different from the patients she cares for, was morally reprehensible. The midwife does not speculate, nor does she state specifically what she perceives this nurse's "problem" to be.

However, the implication is that the midwife's client was targeted by the nurse. Even if the nurse's actions were the result of a twisted attempt at altruism – the offer of an opportunity for the woman to unburden herself of past guilt – the untimely inappropriateness of her questions seems to suggest an ulterior agenda. Whether intended or not, her questions constituted verbal violence against the woman. This assault alienated both this woman from association with nurses and may have affected the emotional tenor of her labour. As a scapegoat, the client's positive experience, and her emotional safety, were sacrificed to appease this nurse's misplaced curiosity. What the midwife impugns about this nurse was strengthened when in the same conversation, she told of another situation in which this particular nurse, alone in the room with a different midwifery client who was admitted to hospital in premature labour, frightened and worried her by telling of similar labours where the birth outcomes were unhappy.

Women in labour, regardless of how strong they are in themselves and how attuned they are to the work of their bodies, are vulnerable to the quality of their environments. The work of labour is focused, all consuming, and often inward turned, as the accounts in Chapter Four describe. It is the job of caregivers and loved ones who support the labouring woman to facilitate this work by being attentive to the rhythms of her contractions, breathing, activity and vocalizations in order to assist her in maintaining this focus while remaining as relaxed as possible (Simkin, 2001). Birth in a hospital is birth in a strange and unfamiliar environment. The company and support of those the woman trusts do much to mitigate the distraction and uncertainty this may cause. However, if jarring, frightening, or emotionally upsetting elements are introduced, as they are more likely to be in unfamiliar surroundings, they inevitably may influence the

woman's experience; alter her focus and relaxation, and the confidence and choices by which she engages in the work of labour.

The action of the nurse in this anecdote was insensitive, lacking in compassion, and highly disrespectful. It not only succeeded in upsetting the labouring woman, but also in heightening her mistrust of anyone but the midwife. She in turn tightened the circle of protection insulating her client from others in their surroundings. This created a dilemma for the midwife, whose priority was the well-being of her client. Excluding the offending or any other nurse allowed her client to feel safer and more relaxed. However, from the midwife's perspective, her safety would actually have been enhanced by the presence of a second caregiver at the time of birth, to be available for the baby and to assist if something untoward had happened. The unethical behaviour of the nurse succeeded in not only upsetting the woman emotionally, and potentially jeopardizing her safety, but also in further alienating and frustrating the midwife. It became another incident in this midwife's catalogue of difficult encounters with nurses.

In situations of judgment, scapegoating and blame an unfortunate cycle of suspicion and mistrust can be set up and reinforced. Rather than moving toward one another, the anecdotes suggest that some midwives and nurses may seek comfort and security within their own groups and with the patients and clients that they consider to be 'their own.' Avoidance, emotional distance, exclusion, walls built of disrespectful words and uncommunicative silence, hurtful action and questionable honesty defeat efforts to care for childbearing women collaboratively. The concern is that midwives' clients may become dangerously caught in the net of this interwoven aversion and antagonism.

Treating with Contempt

Throughout these anecdotes there is a distressing demonstration of objectification in reference to those who are not part of one or another's circle. What does it mean to objectify someone? How is the other viewed when objectified? If I objectify someone they lose their personhood for me. They are reified into a stereotype, and can be disregarded or treated as having little or no intrinsic value (Simpson, et al., 1989). Objectification is a violent act; the violence of disregard, disinterest, or total erasure that may exclude an individual from my scope of significance and thought; the optics of indifference that reduce a person to a thing. The one objectified is unimportant to my goals and ends except, perhaps, as a means or an exigency to be dealt with along the way. In other words this objectified person-thing has little worth in my estimation and I do not feel respect for their unique intrinsic humanity. I may, in fact, feel contempt for them and demonstrate it in either unethically interacting with or avoiding them. To treat someone with contempt, then, is to diminish, or even to nullify them. Contempt may be manifested by discourtesy, rudeness, harshness, a lack of consideration for another's needs or feelings, or even bodily harm. The following anecdotes illustrate participants' experiences of treating or being treated with contempt.

Rudeness and Inhospitality

Midwife Deanna provides an example of how she and her sister midwives are ignored and treated with discourtesy by nurses working on the perinatal unit. As hosts in their place of comfortable familiarity the nurses deny the midwives, the strangers and guests, their hospitality.

> And just to give you just one little example of how we are not part of the system at all up there on the ward: when you are there in the middle of the night, they often make tea and toast or scones. You know, you can smell it. You'll come out to the desk, but they have never once offered some to any of the midwives as far as I know. This is the big joke among us, 'Has anyone been offered tea in the middle of the night yet?' But there will be a doctor coming up the hallway behind you. 'Oh doctor so and so, would you like a cup of tea?' And you know it's just downright *rude*. I don't want to be part of their group, but it's just common courtesy, especially if they know you have been there with your client for twelve hours. (Deanna, midwife)

What is the significance in the sharing of food? It is a sign of welcome, of hospitality, and of communion. It is an act of generosity and often a symbol of inclusion within the community of the stranger, the guest. When one welcomes another to partake in a meal it is in a place that has been made hospitable by the presence of food and company, a home-like place. The taking of food together with others is an act of intimacy in that it involves the satisfaction of a real, embodied need for sustenance, an honest, human need, in the company of others, in communion; that is, in a state of mutuality. The nurses in this anecdote share this 'communion' together regularly. It has become a ritual of their familiar place and companionship. It seems that physicians too are included in this – they are welcomed. When seen coming down the hallway, the nurse calls out to the doctor, 'come and join us, eat with us.' But the physician is a specific person and may be invited because of his or her particular designation and the nurses' foreknowledge and assumptions of his or her place and alignments. The midwife, caring for her client within

spatial proximity to, but apparent social distance from, the nurses and physicians, is not a desired guest. Is she deemed unworthy in some way, or invisible?

Derrida (1999), in speaking of Levinas's understanding of hospitality says that to welcome is to receive, not only in the sense of opening a door through which the guest passes, but also in the "opening of the I" (p. 28) in receiving all that the guest is, before and without her identification by ontological labels, even as an unknown to the host. Elsewhere Derrida (2000) describes hospitality, according to Kant, as a right of the stranger not to be treated with hostility, but this right does not extend beyond the stranger's *attempt* to enter into relationship with the host. On this view, although hospitality is a considered by Kant to be a host's moral obligation, the host is at home and therefore "master in his house – who defines the conditions of hospitality" and can choose who is to be welcomed as a guest. As master of the household, the host has authority and "thereby affirms the law of hospitality as the law of the household ...the law of identity which de-limits the *very* place of proffered hospitality..." (p. 4). Derrida (2000), who adopts Levinas' understanding of welcome as the criterion for hospitality, suggests that because of the host's right to discriminate, Kant's hospitality is not hospitality. The 'I' of the host is not open when the guest is prefigured, pre-identified as one acceptable for reception before she even crosses the threshold.

In this anecdote, the physician and the midwife are such prefigured guests. The nurses, as hosts, extend hospitality to the physician based on this prefiguring and deny it to the midwife on the same basis. This is false hospitality, hospitality that is inhospitable. To offer hospitality as Derrida and Levinas understand it involves risk because the stranger-guest received by the 'open I' is always (to some degree) unknown; and so the

invitation may cause the host to be vulnerable. Was fear of risk or vulnerability what kept the nurses from inviting the midwife to have tea and toast with them? By opening to, and welcoming her, what might they have received in exchange for refreshment in the middle of the night?

The midwife comments that the nurses' lack of hospitality was "rude." This and her statement that she would not want to be "part of their group" indicate that this lack of welcome by nurses toward her and other midwives is hurtful, compounding the distance and estrangement between them. 'Rudeness' brings a constellation of meanings and associations to mind. Rude objects are coarse and rough-hewn, unfinished or primitive. One might have difficulty working with such objects or get splinters in one's hands. Rude accommodations are harsh and uncomfortable, wanting in necessities like food and warmth. Most commonly rudeness is associated with offensive and deliberately discourteous behaviour, even violence against another (Simpson, et al., 1989). Inflicting verbal or physical offense and violence is often a defense against a perceived threat on the part of another. In such a case, the one embodying the threat becomes easily objectified as a menace, not a person. Rudeness is then in essence disrespectful; it is antithetical to consideration and positive regard for the other. Although rudeness may be associated with aggressiveness, voiding of another is equally rude, equally violent.

In a very real sense, hospitality is the work of any caregiver; but, as is shown by nurse Deborah in Chapter Four, it is a particular responsibility for those, like hospital-based nurses, who welcome patients into a milieu that is unfamiliar and associated with suffering and pain. Inhospitality and unwelcome, lack of compassion for human pains such as fatigue and hunger are unthinkable to a conscientious nurse in relating to her

patients. This anecdote shows that the hospital can be a place of discomfort and even of suffering for midwives. Previous anecdotes have shown that nurses too, when entering into the room where a midwife's client is labouring, may feel that this midwifery space is uncomfortable and inhospitable. If an ethics of welcome and hospitality were extended to all, patients/clients and caregivers alike, how might this change the relation between nurses and midwives? It would mean positive regard and intent towards one another – approaching with respect. It would require the intentional use of empathy for deepened understanding and stronger compassion. If such were the underpinning for relation, then even when conflict arises, the basis to support collegial dialogue would be established.

Unwelcome

Midwife Val, also experienced unwelcome in the form of rudeness and disregard when interacting with nurses. Like other midwives, she is aware of how this contemptuous and dismissive attitude affects her clients and contributes to their anxiety.

> One of the hospitals where I have privileges is just horrible. I won't go there anymore. There are a couple of nurses that are wonderful, but you can't rely on them being there all the time. And the rest of them, I have to say... This is typical: I mean I walked up to the floor, and I have been up there several times. I walked up to the desk, and the nurse knows who I am, we've seen each other before. I smiled at her and said, "Hi, I'm Val and I'm looking for my client." She just looked away and she goes, "Oh, I don't know where she is." No smile, no 'Hi Val,' nothing; no niceties whatsoever. Like, I would say that's rude. If you don't smile back at someone and greet them, then you have been rude. And every moment after that is unpleasant. So I said, "Actually, I'll find her myself." Why

would you want to go to a place where when you walk up and you say 'hi' to someone they don't say 'hello' back? And when you say, 'hi, I'm Val,' they don't say who they are. And the clients do perceive it. I mean they're not idiots. They're in labour but they're not totally tuned out to everything. They know when the nurses are in and out of the room. And for the women who didn't want to come to the hospital it really increases their anxiety. You know, they say "We're choosing a midwife. We're getting flack from our family and friends. Are we going to get flack from the hospital too?" The client is concerned about what kind of care they will get in the hospital. "Will the obstetrician come if my midwife calls him? Will the pediatrician be okay? What is the relationship like with the nurses?" Because that *does* influence care. (Val, midwife)

The nurse in this anecdote did not ask the nursing 'how are you?' A question that opens, inviting relation and engagement and shows interest in the person of the other (Cameron, 1992). Instead she offers no response to the midwife standing before her. What is the experience of no response? For this midwife it seems to have been one of being visualized but not seen, of being disregarded; being spoken at, rather than addressed. She does not say how she felt when treated rudely and with 'ignore-ance' by the nurse; however, she does describe the hospital where this type of unwelcome is a "typical" occurrence as "just horrible"; a place she is repelled by and avoids. To have greeted someone and to be ignored is an experience of nullification, of aloneness and separation. The midwife's client too seems to have been erased in this anecdote and she must seek out the client's whereabouts without assistance.

To have initiated a greeting as the midwife did is already to have responded to the other as person, to welcome them. Words of greeting are the invitation to dialogue and relation, signifying recognition of the other as one who has worth and to whom we are open. Levinas says of this invitation when confronted with the face of another, "[...] it is discourse and, more exactly, response or responsibility which is this authentic relationship" (p.88). The other may logically be considered also to have responsibility for welcoming me with the same respect. But in order for me to show this respect in the first place, as in offering hospitality, I can not act based in certainty of who the other is or of their manner of response. As the midwife's experience demonstrates, there is always the risk that a correspondence will not be forthcoming. This is the risk in placing ourselves with openness in proximity with others. As Lingis (1998) describes it,

> When we speak, we speak to others. [...] Whatever we say we put forth for her assent, her sanction, her interpretation, her judgment. To agree to speak, already to answer his greeting, is to have already accepted the other as our judge (p.136).

The moment of opening oneself to relation is the moment of vulnerability.

What kind of place, dwelling, or relational space, is created when there is no welcome? As this midwife suggests, such a place is unpleasant and to be avoided. It seems that the disrespect signified by the rudeness and unwelcome she describes permeated the hospital unit, striking the senses even of inward-turned labouring women under the midwife's care. The women who make a choice for midwifery care do so because it offers a perceived alternative to conventional medical care. To then enter the 'place' of those whom these women have not chosen as caregivers is clearly fraught with anxiety for some. They and their midwives come seeking hospitality in the form of

expertise and care that their midwives can not provide. This is indeed a state of vulnerability. If these women and their needs are not respected, and if their midwife caregivers and advocates are not respected and responded to, will these women receive the care they need in a timely and health promoting way?

Meanness

Theresa, a perinatal nurse, describes an incident that occurred on a very busy shift when disrespect, lack of compassion and unwillingness to dialogue characterized the interaction between a midwife and nurse and effected nursing decisions regarding the priority of a midwife's clients.

> I love what one of my co-workers did – and I think it's why she got reported by the midwife. We were really busy this one particular night, and the midwife had two patients deliver back to back. And none of the nurses was free; we all had patients pushing, you know, getting close to delivery. It was just a crazy, crazy night. And the midwife left her first lady unattended about ten minutes after the delivery because she had to go and deliver the next lady. Which, you know...what are you going to do? My co-worker was the charge nurse, and she and the midwife don't really get along; but she was the only one available to do both deliveries with the midwife. I felt really bad, but there was nothing else we could have done that night. So I guess, because it was so busy, my co-worker couldn't stay. When the placenta was delivered and she felt that everything was okay with the second delivery she said, "I'm done." But the midwife wanted her to stay and do all of the baby paperwork. But my co-worker said, "No, that's your job. It's unfortunate that you had two ladies deliver back-to-back, but that's not my

problem." That was the midwife's problem. Those are her patients and we did what we could for them. But she should sign out to someone or get some extra help in. That's what we would do when we're really busy. We call in extra staff. She should really think ahead that this could happen and prepare for it. And it came up that night that we don't treat her like a doctor. Whatever my co-worker was doing in the delivery, the midwife was saying that, "You wouldn't treat a doctor like that." I think my co-worker said to the midwife that she shouldn't expect us to cater to her. (Theresa, perinatal nurse)

The charge nurse in this anecdote was abrupt and uncooperative toward the midwife, providing her with minimal and apparently grudging assistance. Perhaps the clearest adjective that applies to her behaviour is 'meanness'; she was mean spirited in this interaction. Meanness can encompass a spectrum from disobliging lack of sympathy and stinginess to viciousness and cruelty (Simpson, et al., 1989). It is, then, an emotional hue that ranges from the grey banality of unpleasantness into darker shades of human malevolence. Meanness has relevance to the themes of welcome and hospitality. Another definition of meanness describes conditions of accommodation that are minimal and poor in quality. The conditions of assistance (welcome, accommodation) on the part of the charge nurse were lacking in generosity in this case.

What sensibility prompts one to relate with meanness toward another? The nurse's words suggest some answers to this question. She says that her co-worker and the midwife "don't really get along." Was there an interpersonal antipathy or some history of conflict and unpleasantness between them, which was carried over into this interaction? The words of the charge nurse, as quoted by Theresa, show no empathy or compassion

for the midwife or her clients. Would the nurse in the anecdote have treated a disliked nursing co-worker, physician, or a demanding patient in the same way? Such behaviour is unprofessional, but is it more likely to occur with a midwife than with these more familiar others? Certainly the busyness that night may have contributed to the charge nurse's ill-temper. She would have been responsible for the smooth running of what the nurse telling this story describes as a full and possibly understaffed unit. Perhaps she was annoyed or exasperated at the additional chaos the midwife and her clients added to the already barely controlled demands of the shift. Whatever the reason, she allowed herself to exhibit transparently uncaring feelings. Nussbaum (2003) suggests that "emotions are forms of evaluative judgment that ascribe to certain things and persons outside a person's own control great importance for the person's own flourishing" (p. 22). In this case, to overtly respond in a mean-spirited manner toward the midwife, to leave her to deal with 'her problem' and accuse her of being overly demanding, seems to have demonstrated a negative evaluation of the midwife that allowed the nurse to justify termination of the brief and perfunctory interaction. Rather than respond respectfully in a way that acknowledged the requests and needs of the midwife and her clients – even if simply in apology and explanation for why she could not give them more time – she indulged her negativity.

How is meanness received and experienced? Did the midwife feel hurt, frustration, or anger in this situation? She may have experienced reasonable concern for her clients who were both in the first hours postpartum and so required a modicum of observation and support. All we are told of the midwife's reaction is her statement that the nurse would not treat a physician "like that." To be accused of expecting the nurses to

procure and provide for her unnecessarily could have been heard as insulting. Was it intended to be? Regardless of its truth or falsity it was, in so many words, an implication that the midwife is a difficult and demanding person. Leary and Springer (2001) suggest that criticism of another "inherently conveys a negative evaluation of the individual and, by implication, a devaluation of the relationship" (p.160). Criticism is a means of distancing and objectifying. The criticizer asserts the right to evaluate the criticized. In reaction to the hurt, anger and devaluation the criticized person experiences, they may derogate, that is, reject and further distance any possibility of relationship, and also look for a means of retaliation (Leary & Springer, 2001). The fact that the midwife later reported this incident to the nurse manager may well have been a retaliatory action toward the charge nurse.

What is the meaning of this anecdote for the nurse who recounted it that caused her to "love" her co-worker's actions? Perhaps from her perspective the opportunity that the interaction provided for her co-worker to confront the midwife was long deserved, was a touché in the nurses' favour. The nurse rationalizes her support of this confrontation by suggesting that the midwife should anticipate the possible busyness of the unit as the nurses do. This opinion further reifies the gulf between the nurses and the midwife as well as the view of the midwife as an outsider who should not need, and so is not really entitled to, the nurses' assistance. In this anecdote, as well as the preceding two, the contempt shown toward midwives potentially affects the experiences and optimum care of their clients. If the focus of attention is on the covert or overt aversion between nurses and midwives, childbearing women and their babies are inevitably displaced as the centre of concern.

Intervention and Interface

To intervene means to stand between one thing and another. This recalls the 'middle' in which nurses may find themselves that was discussed in Chapter Five. However, when I intervene, it is not that I *find* myself situated in the centre of something; rather it is that I *choose to place* myself there. Intervention has the connotation of correction or remediation, but it may also mean to join into or participate in augmentation of something. Within this latter meaning, interface is possible. That is, turning toward another, to see their face and respond dialogically, collegially. The following participant accounts speak of intervention and the turn that makes interface possible.

In working together collaboratively, how does one deal ethically with differences in knowledge or beliefs regarding where truth lies? Can there be more than one valid epistemological stance for healthcare knowledge? And if so, how does one appraise another's worldview? When epistemologies and paradigms clash in the perinatal setting, who has jurisdiction over the relationship between mother and baby? Participants in this study responded in different ways when confronted with experiences that raised these questions. For some the answers were easy and action taken with certainty. For others, coming face-to-face with difference called them to question and wonder, allowing them to step outside of their taken-for-granted systems of thought and action.

Trouble Waiting to Happen

Theresa, a perinatal nurse, interacts with midwives from a place of epistemological certainty on which such questions do not impinge. In this anecdote she describes the birth of a compromised baby to a midwifery client. In this situation, she

experiences little tension over her own actions, which are what any prudent and responsible perinatal nurse might have done.

> I've been in a resuscitation situation with our midwife. She thinks if you deliver the baby and it's limp and blue, you are still able to put the baby on the mother's tummy so the mother can talk to it. "Call your baby's name. Call your baby's name." That will resuscitate the baby in her eyes. I don't know what the hell they do at home. But I just go and take the baby. She'll say, "I'm just going to put the baby up on the mother's tummy." "No, you are not!" That's how I have to talk to her when I'm in there. I don't know what the other girls do but that is what I do. "No, you are not putting the baby up there. We will bring the baby back when it's pink." That has happened to me with her a couple of times. And so then I talk to the midwife afterwards about why I did that. Yeah, and I don't know if she knows how to resuscitate a baby because I have done NRP [the Neonatal Resuscitation Program] with her and she doesn't seem to have...I don't know, maybe she isn't familiar with the equipment. But I think she has to have that equipment with her, does she not? I don't think they use it...I would have to guess that they don't use it. It all looks foreign to her. (Theresa, perinatal nurse)

In our conversation, as Theresa described the midwife telling the woman to call her baby's name, there was just a hint of disdain in her voice. Yet, her reaction to placing a limp, blue baby on its mother's abdomen rather than initiating resuscitation is quite understandable. A nurse's presence at a midwife-managed delivery in the hospital is to assist the midwife as necessary, but most specifically to take responsibility for the baby should it not demonstrate adequate cardio-respiratory effort. For this reason Theresa's

concern is first and foremost for the well-being of the baby. In addition, nursing ethos and comportment dictate caution and preparedness for problems; to act for the preservation of life in the ways that are embodied extensions of a salutary impulse. She speaks with the certainty of her professional role which alleviates need to consider the possibility of any action contrary to professional practice standards and guidelines: a baby with poor tone and colour requires resuscitation. Perhaps this is an explanation for the almost aggressive assertiveness with which the nurse takes the baby from the midwife. Is her knowledge also the basis for an assumed right to take control in the situation? Would she have acted in the same way with a physician or another nurse? Perhaps her wariness is more acute when working with the midwife and her clients. She demonstrates no curiosity as to why the midwife might believe that giving a baby to its mother and having her call it by name would serve as a means of stimulation or resuscitation. She speaks as though the perceived urgency of the baby's vital need for oxygen that takes precedence over everything else. Perhaps, in her mind, a little rudeness is justified to expedite what must be done.

Why does the midwife not object to this decisive, pre-emptive action? Perhaps she does not want to engage in an altercation that could upset her client. Did her client, the mother, show concern about her baby's status? Perhaps the midwife is taken aback by the nurse's forthrightness. Or, perhaps she is grateful to have the baby attended to, alleviating unspoken concerns of her own. The nurse's assessment seems to be that the midwife lacked knowledge and good judgment in this situation and tacitly acquiesced to her expertise.

This nurse's account indicates her concern that women and their babies under this midwife's care are at risk due to perceived gaps in the midwife's knowledge and skill. Safety, then, becomes a point of division for her. She speaks as though she has chosen to stand apart from the web of relationship woven between the midwife and her client and the context that it creates. She speaks of her own presence in the midwifery-space as being "in there," implying a barrier between 'there' and the implied 'here,' the context created by the actions and thought processes of her nursing work. The hospital labour and delivery unit, staffed by nurses, is her familiar, social, and cognitive space. Bauman (1993) suggests that cognitive space is created through the acquisition and distribution of knowledge and so is circumscribed by intellectual borders that differentiate as 'other' those who stand outside of them. In this regard, one of the effects of cognitive space is to "keep strangers confined to their places" (p.158). By bringing into the midwifery-space the authority proffered by her professional knowledge, her skill in the use of resuscitative equipment, and the certainty of right action, this nurse constitutes the midwife and family as other, and herself as different from them. The labour-delivery room is part of her familiar context. Her actions assert ownership and administrative power over it in order to ensure the safety of the baby. Does her sense of ownership also extend momentarily to the baby itself? What is the baby's meaning and significance in this situation? The nurse's description suggests that it is the focal point of conflict or competition; the proving ground for right action and superior knowledge. By her action she understands herself to be the baby's advocate and protector. For the midwife, who has had weeks or months of relation-building with the childbearing woman and her family, perhaps it is difficult to fragment mother and baby. Perhaps for her the baby is still one with the

mother's experience of birth. If so, could this have influenced her perceived lack of urgency in the situation?

The nurse's statement that she later spoke to the midwife about her actions suggests that she maintained her professional behaviour by demonstrating a modicum of respect and collegiality. Her words imply that this was meant to be instructive rather than a mutual debriefing of the situation. Did the midwife experience this as helpful, friendly; or condescending? Even in this the nurse indicates confidence in the superiority of perinatal nursing knowledge and experience. The following anecdote reinforces this and lends credence to her concern regarding the midwife's preparation for the responsibilities of practice.

> We don't have much exchange of knowledge with the midwife. It seems that we talk to her and teach her more than she teaches us. That's what I see. I guess maybe she does offer some things, but we don't really listen, maybe. And I hate to say that, but she hasn't instilled a lot of confidence. Regular CBCs [complete blood count], the lab work, will come back and she doesn't know what it means. She doesn't. For example she had a lady with severe PIH and she didn't understand that the decreasing platelets meant anything[11]. I kid you not! Because it seemed like a big surprise when the obstetrician was going over the results with her. You know? It's a bit worrisome. She tells me that she has had all these Women's Studies courses. So, I don't know what she is studying, but I think lab values are sort of important. I don't know, maybe I'm missing something, but that

[11] Decreasing platelets are a sign of impending HELLP syndrome. HELLP syndrome is a serious complication of pregnancy that may be preceded by pregnancy induced hypertension (PIH) and is diagnosed on the basis of four criteria: hypertension (H), elevated liver enzymes (EL), and low platelets (LP). HELLP syndrome can be life-threatening to mother and fetus.

is part of the care that she is providing. Isn't it? Maybe she understands it now, but she didn't a couple of years ago. Some of the things she would say; we knew that she was trouble waiting to happen. She's had a few high-risk patients: the HELLP syndrome one; she had a couple of people at thirty weeks, and thirty-three weeks, with ruptured membranes at home, or bleeding at home. We only found out a few weeks later that this had gone on. She has looked after VBACs that wanted to deliver at home – I don't know how that happened. I don't know HOW that happened! Like, HELLO! Why would you do that? I don't know. Maybe some of her clients are really insistent and maybe they have signed some kind of waiver that if they dehisce[12] at home, then it's not on her head. I don't know. I don't know why people would risk that. I don't understand why someone would want to risk the life of their baby over that, just to have a positive experience for themselves. It's bizarre. My mind just doesn't even go there. (Theresa, perinatal nurse)

Theresa's comments about the exchange of knowledge between nurses and the community-based midwife express disregard, albeit apologetic, for any expertise the midwife might have to offer. This, she suggests, is due to a fundamental lack of trust in the validity and appropriateness of the midwife's knowledge and her sources of knowledge. She goes on to highlight the midwife's ignorance regarding critical diagnostic information, essential for the health and safety of pregnant women, and her apparent inability to make competent judgments regarding situations of risk for her clients and their babies. The value accorded to nursing knowledge defines the nature of risk within measurable, rational, evidence-based parameters. A woman with HELLP

[12] Dehisce: The rupturing of a surgical scar; in this case, the previous caesarean section scar.

syndrome, premature rupture of membranes, bleeding in the last trimester, or a previous cesarean section would, indeed, alert most caregivers, and particularly those whose knowledge is based in the conventional, biomedical model, to the need for careful surveillance and/or intervention. Perhaps part of the indignation expressed by this nurse is related to the degree of responsibility the midwife has for her clients, which, combined with what she perceives as ignorance, may indeed place midwifery clients in very unsafe situations. Understandably, the nurse seems to question the appropriateness for perinatal caregiving of the knowledge and understanding that the midwife might have gained through study within a critical, socio-politically oriented discipline such as Women's Studies. Nevertheless, for the midwife, perhaps there are kinds of knowledge about women both collectively and as individuals other than just the biomedical that are equally important and in keeping with the holistic model of care on which midwifery is based. Perhaps both Theresa and the midwife view the nature of safety and risk, normal and abnormal from the 'truths' of their individual experience. How can different knowledges and truths in such a situation be brought into congruence? Is it possible for Theresa and the midwife to be curious and open enough with one another for exchange and reciprocation to lead them to a shared truth (Bergum, 2003)?

The social-cognitive space in which the nurses reason and work includes other nurses and physicians. Within it midwives may be anomalous. By viewing them as incompetent, ignorant, or simply hazy and "never-fully-formed" (Bauman, 1993, p. 156), midwives, and even their clients, (deemed to be selfish and irresponsible in the account above), can be kept at a distance, feared, disdained, or tolerated as comfort and self- or group-definition dictate. Theresa says of home birth VBACs, "My mind just doesn't even

go there." In this frame of mind reciprocity is almost impossible. Assumptions and boundaries impose control, keeping some in and others out. What might impel her to loosen those boundaries without giving up integrity and so allow another – the midwife – into proximity and a more collegial relation?

Admiration and Anxiety

Alison describes a situation similar to the birth of the compromised baby related by Theresa above. Alison demonstrates a sense of ambivalence that is absent from Theresa's experience. The source of this ambivalence, in part, is a tentative openness and interest in the midwife's ways of working and her understanding of birth.

> And I think that the midwife has a lot to offer us too, as nurses. When I worked with her just a little while ago the baby had a lot of decels[13]. When she delivered it she did a maneuver I hadn't seen before to untangle the baby's head from the cord. I really liked that. Now, if I ever get stuck with a tight cord, I will be doing that. When the baby was born it was quite blue and having a hard time breathing. And the midwife said that this was not the medical model so she wasn't worried about it. I really bit my tongue and just let everything be. But it all turned out just fine. (Alison, perinatal nurse)

Alison seems to admire the midwife's skill in dealing with the tight umbilical cord, perhaps wrapped around the baby's neck or body, and values what she witnesses and learns from this simple direct action. Arendt (1998) describes how witnessed action can define us as unique in ourselves for one another. She says that this occurs "where people are with others and neither for nor against them" (p.180). Alison's perception of

[13] "decels": fetal heart decelerations, noted either through auscultation (listening by means of some form of technology), or by a specific pattern on the tracing from an electronic fetal heart monitor

who the midwife is, is inevitably altered in some way in the instant of observing this action, a new skill that has utility and meaning to her for her own practice as a nurse. But, not only has Alison gained new knowledge from an unexpected source, the source itself, the midwife, has become more distinct for her as a person. In this experience she suspends judgment and categorization and so is able to stand with the midwife in a moment of mutuality. This action builds a tenuous bridge between them.

This anecdote is about the birth of a stressed baby and in it we also see this nurse's concern and anxiety regarding other actions, or lack of action, by the midwife. The nurse said she 'bit her tongue' when the midwife did nothing to respond to the baby's colour and respiratory effort, both of which no doubt worried the nurse. Perhaps a tension arose here between her admiration of the midwife and this anxiety. Was the bridge span of recognition and respect which the midwife's maneuver to relieve the tight cord threw between them destabilized seconds later by the midwife's choice not to acknowledge the need that the nurse perceived for resuscitation of the baby? Was what this nurse began to know about the midwife moments earlier is plunged again into question and further complexity? If so, why did she not intervene as she would have if a doctor had been managing this delivery? Was it her trust in neonatal resiliency, or in the midwife's judgment, or was it some quality in the particularity of that event? What would her words to the midwife have been had she spoken? Perhaps the midwife anticipated or read anxiety for the baby in nurse's silence. Perhaps too this silence was due in part to a curiosity that overrode her anxiety; enough curiosity to want to witness what the midwife's care of the family, based on knowledge and understanding from a different 'model,' would entail.

This nurse relates the midwife's words, which suggest that this birth was somehow taking place in a context different from that which is presumed for a hospital birth; a context socially and cognitively created by the midwife, the birthing woman and her family. By acting as a midwife, bringing to this birth her midwifery knowledge and skill, as well as her relational knowledge of the woman, she shapes the 'social space' (Bauman, 1993) of birth. Clearly, for her, it is different from the surrounding 'cognitive space' (Bauman, 1993) of the hospital. The midwife implies that childbirth within the space created by medical knowledge and understandings is perceived as a much more worrisome event. Perhaps she assumes that she and the nurse have different understandings of risk in this particular situation; and, that the nurse stands outside of the safe, intimate space that she and the mother and baby have created. However, it seems that the nurse is willing just to be there with the midwife and the birthing family, cocooned with them. She is willing to allow the awakening and oxygenation of the baby to unfold inevitably within the unique space of this birth.

One might understand from the nurse's words that her usual response would have been to object or step in to control events. This would have meant taking the baby from its mother and so intruding into the rhythm and harmony of the unique midwife-and-family-created context. Had she done this, the action would have been in keeping with both her accustomed role, and, likely, the expectations of her fellow nurses. Interventive action on her part would also have been congruent with nursing professional ethics and standards of practice, which hold patient safety (in this case the baby's) as paramount. However, it would have meant an alteration in the 'moral space' of this particular birth (Bauman, 1993).

Bauman (1993) describes moral space as a context that ignores and dismantles cognitive spaces. Cognitive space is shaped by rationality, rules, communicable knowledge and the assumptions that derive from them. It supports the objectification of certain others in order to allow for unsympathetic coexistence. Moral space arises out of concern for others, which does not result from entitlement or membership, does not differentiate nor objectify, but exists for the benefit of individual, irreplaceable persons. Bauman also posits that the proximity within moral space may be most compelling when it overlaps with (cognitive) knowledge of the other. Perhaps this nurse was willing to transgress professional behaviour and obligations, the cognitive space of nursing, because she witnessed, respected and was drawn into the moral space supporting this moment of new relation between mother and baby, the integrity of which was supported and protected by the midwife. Might not such a space be dangerous? Why was the nurse not compelled by a singular sense of moral responsibility for the baby? Was there professional angst in this situation? She is caught in ambivalence and incongruity between admiration and dawning respect for the midwife, recognition of the mother-baby relation, and anxiety over the baby's wellbeing and her professional responsibility in the situation.

That Sort of Irony

Like Alison, Vivian also expresses a mixture of feelings regarding midwives and her experiences in working with them. Although she is not without concern and acknowledges the inequity of situations nurses sometimes find themselves in while accommodating midwives, her more positive take on the exchange of knowledge suggests the potential for understanding and mutual respect.

I actually feel badly for some of the midwives because I think a lot of the problems arise out of good old-fashioned bravado on their part. They don't want to come across like they are insecure and so they go too far. I mean some of them are obviously really inexperienced. And, you know, it's clear that they are in over their heads. And if they could, maybe, be just a little bit more up front about that... For example, you know, just basic running across complications and not really knowing how to deal with them. And needing a lot of guidance about what to do next and how long it is appropriate to wait, not recognizing some of the signs of fetal distress even. Like basic fetal monitoring stuff. They're just not as experienced, and so on.

But on the positive side, what I do see, in my view that is, in the same way that I remember being nurtured myself as an inexperienced nurse, and the way that I see the interns being nurtured by the experienced nursing staff, there is a lot of nurturing that I am seeing. There is an attempt on the part of the nursing staff to do some of that nurturing of midwives. You know, in a respectful kind of a way. So I think if they're open to it, it could be a good thing. But having said that there is still that sort of irony that the nurses are nurturing the midwives, who have put themselves in a situation where they're saying that they have autonomy. But we nurture the young doctors too; so, I mean, we have to do this. (Vivian, perinatal nurse)

Vivian's words express a mixture of compassion and annoyance. In working with midwives she indicates a necessary watchfulness for areas where the their knowledge may be lacking. The implication is that may be worrying for nurses when they see

situations where these knowledge deficits could put women and babies in danger, and when, as the use of "irony" suggests, she expects greater knowledge and expertise of midwives than some of them demonstrate. Although there is a tone of sympathy for their inexperience, it is what she as lack of admission regarding knowledge deficits that seems to concern her. She does not complete the sentence in which she mentions this, beginning with "And if." Perhaps the expected 'then' statement, which is left unsaid, would be that being "up front" might pave the way for a more respectful and collaborative relationship between the nurses and midwives; one in which knowledge and information could be easily shared and the risk to childbearing women reduced.

In telling her story of becoming a perinatal nurse, Vivian spoke of being mentored by hospital-based nurse-midwives who generously guided, challenged and supported her. As a result, she is an advocate for such collegial transfer of knowledge and insight. She emphasizes the respectful "nurturing" of the inexperienced midwives by some nurses, despite the irony of the situation. This nurse seems to hold this situation within a compassionate frame that suggests this mentoring and nurturing is part of nurses' ethos. In the mutual openness and engagement of the act, assumptions regarding hierarchy and legislated autonomy can be brushed aside.

Collegial Respect

Kathleen, a labour and delivery nurse, speaks of her work with midwives in a positive and hopeful description of ethical collegiality, which points in the direction that mutual respect and understanding can take us. In her words the integration of helpful intervention and collegial interface is complete.

It's wonderful to work with them. It's good working with midwives. Usually I will go in and say 'Hello' to the family the same as I always do...And I work with the midwife to provide care, so we will talk about who will chart, in particular. These things have to be negotiated. The midwife is there, usually continuously, unless she is absolutely exhausted, in which case she might go for a bit of a nap, and leave me. Or, if things are going fine, she might have break and leave me looking after the woman. But I think the expectation of the families is that the midwife will be there caring for them and taking the lead in coaching for birth positions or trying a bath or aroma therapy. It's a wonderful opportunity to work with them and to see that in action – and to be part of the team. And so I get in there as much as I can. If the midwife is fine, and the family is fine with having me there partnering with her, it's usually very pleasant... So, my role as a nurse is quite different because I'm not in charge of the woman's care; but I'm still there to be a support to the family and to the midwife. It's fun, it's wonderful, quite wonderful. (Kathleen, perinatal nurse)

This nurse clearly enjoys participating in the care of midwifery clients. She is respectful of the family's expectations for care by their midwife, yet delighted if she is called upon to spend time relieving the midwife during a break. She speaks of negotiating duties. This suggests respectful communication and co-operation as well as interdependency in order to see that necessities are anticipated and the midwife is freed to focus on her client. Although she does not practice within her full scope as a perinatal nurse when the midwife is directly engaged with her client, Kathleen seems to understand that she has a role as a nurse and can be engaged in the woman's care even when in the

background. This engaged attention is suggested when she describes her work with the midwife as "partnering," and as being a "part of the team." D'Amour, et al. (2005) describe partnership as collegial collaboration in an undertaking based in an authentic and constructive relationship. Rather than bringing a passive or critical attitude, she stands with the midwife, practicing within a relationship of mutual respect and mutual support, both critical attributes of collaborative interprofessional work (D'Amour, et al., 2005; Schober & McKay, 2004; Stapleton, 1998). This is a dramatic and welcome contrast from previous accounts. Here we see collaboration for truly woman- and family-centred care. Yet she is clear that her role is one of support and does not impose her presence in the room unless it is desired and comfortable. Kathleen expresses openness and curiosity regarding what she may learn from the midwife by being included. This demonstrates a respect for the differences between her own professional culture and epistemology and that of the midwife. Underlying this, once again, is respect and perhaps trust, in this case, that the knowledge and approaches utilized by the midwife are safe and acceptable to the client. However, her interest and acceptance is not unthinking or unobservant as the following shows.

> Sometimes a midwife will have a woman in second stage for a very, very long time. But I think if you are working with them, you realize what the family really wants. As long as the baby is okay, and the mother is okay, and you are working with her to do the best you can to have a vaginal birth... That is really where the midwives will go beyond what we would do. They are a little bit more hesitant to say, 'Well, you need some oxytocin because the contractions are just not powerful enough.' ... But as long as that is what they want, the baby and mom are all right,

everybody is safe and healthy, really, it's no harm done. It will just be a longer labour, but no harm done.

As a conscientious perinatal nurse Kathleen demonstrates vigilant thinking regarding the health and safety of women and babies, but is also a willingness to trust in the woman's responses to her labour and ownership of the birth. Significantly, she also implies trust in the midwife's judgment and understanding of the birth process for the individual woman. There is a hint of discomfort when she speaks of a long labour, but she seems willing to suspend her own judgment and respect the authority the woman has placed in her chosen caregiver. Stapleton (1998) suggests that presenting a "unified front" (p.16) to the patient/client is essential in successful collaboration. This means interacting with colleagues with respect for what they contribute from their professional discipline to the joint effort, and communicating to patients/clients that the caregivers trust and respect one another. Kathleen does this, recognizing differences between herself as a nurse and the midwife, but placing the best interests and autonomy of the woman, as well as her relationship with her midwife, at the centre of their interactions.

Locating Difference

In this chapter the relational ethics of interactions between nurses and midwives have been explored, primarily through unethical exemplars. It is remarkable that when asked about experiences of their interprofessional interaction, the majority of stories that spilled out in my conversations with participants were full of complaint and frustration towards members of the other profession. I do not think this emotional tone is at all characteristic of these individuals, but rather a product of the differences experienced in

the structural/institutional, disciplinary and epistemic cultures in which they are situated. The problem of 'difference' is one of the major challenges in collaborative interprofessional healthcare practice. Differences in accustomed practice environments, the quality and duration of relationships with patients/clients, epistemological orientation, disciplinary worldviews and the expression of these in comportment and practice style, degree of practice autonomy, social status, and education have all been identified as barriers to collaboration and team-building (Hall, 2005; Keleher, 1998; Stapleton, 1998). And all have relevance to the experiences of the participants in this study. If left unaddressed these differences can lead to misunderstanding, competition, withdrawal, domination, mistrust and conflict (Keleher, 1998; Stapleton, 1998). These reactions to difference also resonate with the stories presented here.

When caregivers are consumed with this disequilibrium between themselves, the mother and baby may be lost as their mutual focus. Considering the significance of the childbirth event in the lives of those whom these caregivers serve, it is imperative that the source and meaning of nurses and midwives relating begin and return here. But what is the significance of birth? How do we begin to explore its meaning and find renewed, reconciled community in it? For this we must return to relation and to difference, both of which, in addition to the meaning of birth, are taken up in Chapter Seven.

CHAPTER SEVEN

BIRTHING INTERPROFESSIONAL RECONCILIATION

This study began with the following questions: What are nurses' and midwives' experiences of caring for childbearing women? What are their experiences when they interact to provide this care? And what meanings are embedded in these experiences? These questions were asked as a way of exploring a problem, and more particularly a mystery. The problem, as it has unfolded, is that of dealing with or managing differences/unknowns between oneself and another, which, as the data show, contribute to aversion and conflict. But the mystery is that of relation with another, particularly a different other. The impulse to seek relation, like the moral impulse, finds its roots in an internal imperative (Bauman, 1993) and ultimately cannot be educed by a set of solutions. Although a set of solutions – the response to a problem – may assist in creating a context in which relation may flourish, what is required in order to enter the mystery of relation is a desire within the individual to be welcoming and to extend the grace of respectful curiosity to another in their alterity.

There are many intense examples of the human experience of relation (finding a best friend, being in love, connecting with a mentor); experiences in which it is as if the body knows before the mind the importance of relation with the particular person. There are also relationships that grow slowly over time and come to light when, one day, one becomes aware of a deep liking for another. However, perhaps the most primal and powerful example of this impulse to form relation, and one in which welcome and curiosity are signs of emotional health, is the relation between mother and baby. Object

relations theorists such as Winnicott (1989), Chodorow (1999) and Hartsock (1983) argue that this mother-infant relation creates the inner crucible that shapes all subsequent important relationships. Although the infant's need for relation with the mother or some surrogate is absolute, certainly a woman's desire to bond with her infant is not always immediate upon giving birth; however, a positive emotional and relational context for the birth can greatly facilitate this experience of interest and desire. One of the most important roles shared by perinatal nurses and midwives is that of being present as a facilitator to this initial bonding. How does the caregiver's understanding of the care she gives nurture this relation between mother and baby? How might the relational atmosphere surrounding nurses and midwives together at the time of birth impinge on this nurturance and on the quality of the moral and emotional space created by the birth? In order to contemplate these questions, it is necessary to return to what perinatal nurses and midwives show about the significance of relation and the centrality of the mother-infant bond.

The Meaning of Relation with Childbearing Women

Cameron (1998, 2006) writes of the 'presentable' and 'unpresentable' in nursing identifying that which is 'presentable' as a representation of nursing in theory. The concepts and systematic conceptual relationships that formulate nursing hypothetically are abstracted from the lived, embodied work of caring for individual patients and clients in everyday practice by the necessary rarification of generalization for inclusion in a disciplinary body of knowledge. Such representation is important and essential as it provides the basis on which nurses are educated and socialized. However, imparted along

with this idealized representation of nursing is always the caveat that nursing action should take place within the mutual understanding between nurse and patient of the patient's unique situation and context. The actuality of this mutual understanding and the relation that it speaks of is invisible in the 'presentable' because understanding and relation between nurses and patients – and midwives and clients – opens out a vast, complex and individually wrought landscape of unacknowledged recognition, interpretation, action, and interaction; that is, the 'unpresentable.' Drawing on the philosophical work of Lyotard, Cameron (2006, p.24) describes the unpresentable in three ways as that which is: excluded or ignored because the dominant discourses have no categorical identifier for it; incommensurable with theory and therefore is misrepresented as something else; and/or the horrific, unthinkable, or obscene, that defies categorization and reduction within the discourse. Nurses and midwives both experience the 'unpresentable' in practice in ways that correspond to all three of these definitions: the unacknowledged, the contradictory, and the unthinkable. Using the bathing of a patient as an example of the unpresentable Cameron (2006) asks,

> What does the theoretical representation say about what it is like to stand before a naked human being? Here we realize how the existing rules of nursing discourse have systematically misconstrued this act of nursing that is so elemental in nursing practice as an act of hygiene alone. In their unique understanding and integration of knowledge with the situatedness of practice, nurses develop a particular way of approaching the irreducibility of concrete human situations (p. 25-26).

Like the bath, the physical contact between a nurse or midwife and a pregnant, labouring or lactating woman is complex with meaning and irreducibly human. Only those who perform the concrete caring know what it is like to check the progress of labour via a vaginal exam, seeking the message from the cervical os and bony presenting parts; to palpate a pregnant abdomen allowing the hands to bring the image of the fetus within to the mind's eye; or to gently hold the peculiar shape of a woman's breast in order to assist her baby in obtaining a good latch on the nipple. These aspects of nursing and midwifery, touch and voice and the knowledge of women's and infant's bodies, are unpresentable both because of their absolute unrelatedness to the chimera of lust that conventional associations regarding certain body parts conjure, and because they are so deeply engaged with the 'being' of flesh; carefully enacted in the moment in attunement with the woman, baby and context. Such actions bring together the mother's past and her shared present with her infant, and their effects ripple outward into the future for both, as well as for those they love. Childbirth and the relation between mother and infant, as the foci of perinatal nursing and midwifery, hold the purpose and meaning of the work that these caregivers engage in. How do nurses and midwives manifest these meanings and significances in their work?

The Meaning of Birth

All of the participants in this study acknowledge that childbirth is a physiologically natural event for women in general. That is, the norm anatomically and physiologically for perimenstrual, endocrinologically fertile women is to be able to conceive, gestate and vaginally birth offspring. They also acknowledge that this norm is

not the case for all women all of the time. The participants describe childbirth as 'natural' in ways that demonstrate two different understandings of the word: one as a force of nature that is visited upon a woman in unpredictable ways; and the other as a developmental experience that arises from the whole and embodied nature of the woman herself. On the first understanding, the woman has little or no control over the way in which childbirth occurs; and on the second women have as much opportunity to take control by making choices as they are psychically willing and able to grasp. In this study, it is primarily nurse participants who expressed the first understanding of childbirth and midwife participants who expressed the second. These different assumptions about the nature of birth are shown in the two birth stories presented in Chapter One through the language that the participants use and their focus in relating the stories. Nurse Jenna speaks anatomically of the mother's body and the ways in which its relation to the fetus is unpredictable, problematic and divorced from the mother as a subject. There is no such emphasis or language in midwife Leona's account; rather she describes the context of the birth, the activities of familial relation, and the mother's enacted preferences in birthing her child.

These views are not entirely contradictory nor are they necessarily dichotomous. Rather they bleed into each other depending on individual caregivers' interpretations in specific situations. Moreover, unpredictability does not necessarily negate opportunities for women's decision-making. That is, a woman may have unexpected events arise that alter the course of her pregnancy and parturition and yet may still retain a sense of control and of the experience being guided by her own choices regardless of her caregiver. However, emphases within which childbirth is framed by understandings of the woman

as mother/creatrix and the mother-baby relation as on going union, or mother as object body and the mother-baby relation as the splitting off of distinct entities, typify midwifery in the former case and medicine, and to a lesser degree nursing, in the latter. In addition, these two views are rooted in different beliefs and assumptions regarding the presence of risk and how risk should be addressed based in the knowledge and technology available to the caregiver. The variance in these understandings of risk as they relate to childbirth can be peeled away to reveal a constellation of factors that shape caregivers' understandings and ways of being. These include the ways in which the nurses and midwives acquired their knowledge for practice; the physical and social contexts of that practice; the standards, institutional policies and protocols that conscribe it; the worldviews, ethos, and personal experiences that called them to become perinatal nurses and midwives in the first place, enlighten and motivate their work, and deepen their expertise and wisdom as professionals.

The contexts of practice shape the relationships that nurses and midwives have with women, their babies and families. As discussed in Chapter Four, nurses often encounter their patients for the first time in labour, the early post partum, or in the antepartum period because of some pathological process that is affecting the pregnancy. In this sense the woman and her child, whether fetus or baby, come to the nurse as new acquaintances and unknowns. Birth, too, as a process in which the nurse participates, is viewed as an unpredictable unknown in its particular manifestation with this woman, this child. Wariness is heightened, along with detailed preparation for the untoward. The unknown aspects of the birthing woman and her baby, combined with responsibility for her health and safety with which nurses and all healthcare providers are charged, can be

seen translated into the architecture and appointments of the labour room. The hermeneutic substratum to this preparation and anticipation of danger is the understanding that birth and death are not unfamiliar companions. Women choose to birth in the hospital because it is safe. Nurses, physicians, technology and medically interventive capability are part of that safety net constructed into the hospital setting. What the unknowns may manifest, and the approaches for addressing these manifestations, are abstracted and represented in theory and algorithms that responsible perinatal caregivers learn and incorporate, and are reified within the space set aside for hospital birth. The shadows of morbidity and mortality linger in the corners and behind curtains.

The relationship between nurse and woman is intense and focused. Perinatal nurses carry the knowledge that childbirth may be easy and low risk and hope for this for their patients. There is welcome and positive regard shown toward women and their families, but because nurse and woman come together as strangers there is little time to learn what a woman is capable of in herself or how much the trust established between them will withstand problem-solving and non-medical efforts by the nurse to assist a woman to push past her fear and discomfort. For this reason, reliance on theoretical understandings and available technology (the presentable) may eclipse what knowledge the nurse has been able to ascertain of the individual woman. In addition, because they work in an environment that has been constructed in anticipation of risk perinatal nurses see many scenarios played out that confirm a view of childbirth as potentially dangerous and unpleasant. Interventions such as epidurals, inductions or augmentations of labour, caesarean sections or instrumental deliveries become commonplace to the point where

they may be understood as simply prosthetic extensions of how a woman's body gives birth.

This view of the means for birth can lead to misunderstandings between women and their nurses when, postpartum, women express disappointment with their experiences of childbirth. For many nurses, a safe and healthy baby delivered to its mother is the most important meaning birth holds. This understanding may be without consideration for the disjuncture a woman's experience of birth, when accompanied by unanticipated interventions, can cause in the relationship between mother and baby that follows. Perinatal nurses in this study express an awareness of birth as a major life transition for women and families, and the significance of bonding between mother and baby as of essential importance and to be encouraged and facilitated. However the compartmentalizing of the birth experience as a discrete event to be managed by relative strangers in an institutional environment sets it apart from the relational continuum between mother and baby begun in pregnancy where the mother's body and ability to grow life was understood to be relatively adequate and safe. The nurse steps in to help the woman through the immediacy of the birth using all the knowledge, skill and compassion she possesses. However, the constraints of time and place on the nurse-woman relation contribute to a particular frame for experiencing and understanding birth as primarily the means to an end; a problem to be addressed by the best solutions. Although the nurses in this study indicated deep respect for the significance, the 'mystery,' of the mother-infant relation, the circumstances of practice inhibit the depth with which they are able to address it. The healthy baby becomes the prize and the achievement by which the event of birth, and the caregiver, are measured. Although a healthy baby is indeed highly prized

by any perinatal caregiver, this represents a somewhat different understanding than that communicated by the midwives in this study.

Over the time before birth, during lengthy prenatal appointments, midwives and their clients come to know each other relatively well. The midwives in this study spoke of discussing with their clients what the women's hopes for their births are, how previous births had been, and what they had been told about their mothers' and other family members' birth experiences. Midwives also have the opportunity to assess a woman's feelings about her pregnancy as it progresses, the family context into which the baby will come, and the woman's self-confidence and desire to make choices. Chapter Four illuminated the growth that occurs for many women in the context of the midwifery relation and how it equips them to recognize where choice exists and to take responsibility for choosing in matters of their own and their family's health. It is possible, from early on, for midwives to foster and share in a celebratory attitude regarding the pregnancy, the growing fetus and the process of maturing motherhood, instilling a sense of hopefulness and empowerment. Birth is viewed as an important event, a nexus in which mother and child meet in a new way, but still a part of the journey on which mother and child and family embarked together. The midwife joins them on this journey and the places of their sojourn together invariably include, at some point, the woman's home and intimate spaces. For the midwife who chooses to, there is time to contemplate and explore the mystery of the individual woman who is one but also two; whose bond with her child will evolve from embodied unitary chiasm to chiasmic dyad (Wynn, 1997) in the ever strengthening emotional and psychic ties of maturing parent-child relation.

Regardless of the context for the birth – home or hospital – or the means by which it comes about – vaginal delivery or caesarean section – continuity is maintained through the midwife-client relation that bears knowledgeable witness to the relation between mother and child. The woman comes to birth confident that she will have an opportunity to make informed choices, and deeply comfortable with the person she has chosen as her resource and guide. In this regard, although risks may be present, they may not be as fearful, and necessary interventions less disruptive within acknowledgement of the larger picture of the mother-baby dyad. For midwives in this study the meaning of birth is the woman as life-giver, mother, who brings herself to birth together with her child. This meaning of growth and transformation for the woman is understood for its profound potential to give resiliency and strength to both mother and child as they live into their future lives.

Both nurses and midwives in this study spoke of the hopeful and even miraculous nature of birth; the 'natality' that calls us with purpose into deeper involvement with the world (Arendt, 1998). They acknowledged the transformative power for women that bringing new life from their bodies can have, and the joy of watching families take shape. All participants spoke in varied ways with passion about the privilege of participating in the lives of women and families at the time of birth. The power of this event calls these caregivers to want to witness and participate in it as their chosen work.

As Irigaray (2002) suggests, birth is the ground of being; the phenomenal evidence that, from the moment of conception, we cannot be ourselves, we have no true humanity, without relation to an 'other,' the mother, who is different from us. In fact we cannot even exist except that two 'others,' profoundly different from each other,

contributed to our being. This necessary coming together of difference and subsequent gestation of a third different 'other' are the ground of being not only in the purely biological sense but also in the sense that to be fully human is always to be in relation. For the period of gestation the relation between mother and child is deeply chiasmic as the woman and the flesh and bone of her developing infant are held within one flesh, her own, touching and being touched, one but also two (Wynn, 1997). The two hold a hiatus, a space of unknowing and 'listening' between them, open yet quivering with curiosity, need and desire (Irigaray, 2002). At birth, knowledge of the child as other comes to revelation for the mother as all her senses are filled with the new being who until then only was known through haptic messages, curls, stretches and rolls within and, perhaps, the cryptic, visual abstractions of ultrasound. The child at birth is both anticipated, prefigured gift and stranger to her. The space of unknowing still hangs between them and, if anything, has become more complex as the sex, physiognomy and, over time, personality of the child are apprehended.

The relation between mother and child is for the infant, beginning at birth and over the ensuing weeks and months, the first falling-in-love. As Wynn (1997) describes, the chiasm of mother and child continues through a sensuous overlapping and connecting in which the mother engages in a new embodied listening to the unique massages of the infant's voice, breath and body directed to her as the 'other' in the infant's sphere. She responds with the singular touch, nourishment, warmth and voice that is her being toward the child. This speaks both of the integrity of each and their continual coming-into this integrity through relation with one another (Irigaray, 2002). Theories of psychoanalysis and the unconscious effects of the mother-infant relation, which might try to explain how

the lives of individuals unfold from birth, are not appropriate to this study. However, the power of this relation, its formation in the mother's body and continuance from birth onward, this ground of being, is part of what nurses and midwives, and all humans, share as we share the biosphere and air that sustain us. To witness birth, then, to be privileged to take part in facilitating it, is to enter into and perhaps influence the mystery of relation at its core.

Caring 'Together'

The time of birth is full of enormous significance, and as the space, the air, the vibrating energy of atoms are shared by all present at this moment of mysterious transition and revelation it seems immoral to bring disturbance to the event through the negativity of non-relation. If we explore this mystery of relation with the other as it is lived beyond the maternal-child relation, as it broadens out from it into life with others, troubling questions arise regarding the presence of prejudice, discrimination, exclusion and hatred that so often characterize human interaction. For example, what underlies or causes the rudeness, meanness and alienation between some nurses and midwives, in a negative sense a most unpresentable aspect of their inter-professional interactions, particularly at the time and in the space of birth, as shown in this study?

Adult relationships do not have the dependency that a child has for its parents, nor the same type of commitment and instinctual protectiveness that parents feel for their children. We grow out from these primary relationships to engage as autonomous beings with others in the world. Our own being is shaped by experience, language, culture and all those entities that frame and constitute the horizons of our lives. We accept that as

humans we experience fear, anger, antipathy, annoyance and myriad other emotions that are not, at least in the moment of their experiencing, conducive to comfortable relation with another. And yet these moments have the potential to be inverted through dialogue and reconciliation, to lead to the blossoming of respect, if not actual liking. Our ability to engage with negativity in this way may present challenges; however, there are resources that can either assist or hinder us in turning such situations toward reconciliation, or at least away from destructive conflict.

The resources are both interior, inhering in the self, and exterior, anchors related to the specific context and our understood roles and responsibilities within it. Perhaps the most powerful interior resource is self-love and self-understanding. Such self-respect frees one to show unthreatened interest in another. The roots of these aspects of being are too vast and complex to be addressed here; nevertheless, to some degree the strength or weakness of these interior resources can be said to derive from the constitution of our individual horizon. This includes life experiences, conscious and pre-reflective actions and ways of being, and also the meta-narratives within which our lives take shape and the degree to which we have been required, or have chosen, to challenge or accept them. As discussed previously, nurses and midwives often approach birth from different yet somewhat overlapping paradigms that shape their horizons, contexts of practice, comportment, and interpretations – their being – as professionals. These worldviews, or woman-baby views, contribute to the quality, strength and situatedness of their exterior resources, their roles and responsibilities, the structures within which they choose to work and dwell, and shape their interactions, providing perspectives or lenses through which to read one another.

Although nurses are educated and socialized within a horizon largely derived from medicine, nursing tends to stand apart from its power structures except, as demonstrated in this study, when alignment with physicians is a more comfortable alternative to alignment with midwives. Nursing has its own body of knowledge that in subtle but profound ways is influenced and converted by the 'unpresentable' in nursing practice as described by Cameron (2002) above. The skilled nurse's work is a continuous flow of the unpresentable that holds the 'presentable,' in suspension both implementing and questioning its theoretical premises. This interweaving of scientific knowledge, knowledge of the individual patient, and the nurse's self-knowledge form the blanket of care within which the nurse comforts, and nurtures her patients. The way in which this is carried out, the dance of nursing, is in its unique totality unlike that of any other health care profession, although many skills and the expressions of human caring may overlap.

Aspects of the unpresentable in nursing are pre-reflective or intuitive; however, there is also much that is born out of a continuous dialogue, not always spoken, between the nurse and patient as selves, and between the embodied mind of the nurse with the patient's body (Cameron, 2006). This is carried out, successfully and meaningfully in the hospital context, against and in spite of what for the patient may be a disorienting, alienating, institutional backdrop. In this sense, much of the relation between nurse and patient is expressed through the beautiful 'doing' of the nurse and the resulting comfort of the patient. These aspects of the being of nursing are to be acknowledged, respected and valued. Nurses can take enormous self-affirmation from this unique work in which they are engaged. If within the unselfconscious, self-valuing, at-home-ness in this 'doing' the nurse is able to open to the alterity of the patient, acknowledging yet comfortable with

the differences between them, the space of unknowing as a space of silent perceiving, listening (Irigaray, 2002), can be incorporated into the dialogic dance of care making it unique and appropriate, enriching both. The particularity of the unpresentable with this patient at this time and place allows the nurse to suspend categorical judgment of this other. I speak here of the nurse, but the same suspended judgment and openness toward the other exists equally between the midwife and her clients.

For the midwife there is greater time to know her client through verbal interaction and through being together in different times and places. In addition, this growing relationship takes place during a time when the woman is in the more or less comfortable physical state of pregnancy, rather than in the extremis of labour or the joyful but radical upheaval of new motherhood. This longer relationship, based in verbal as well as embodied dialogue can build a solid bridge of understanding across the differences between midwife and client, and deepen the commitment and quality of the exchange that passes between them. When a woman and midwife come into the hospital, this established relationship buoys them both in an environment that is less familiar. When together, the focus of one on the other creates its own environment, transforming their corner of the institutional space into a protective envelope for the woman. It is not surprising that some nurses in this study felt excluded by the intensity of this relation. The midwife too draws on the presentable aspects of professional care; the standards of midwifery practice and obstetrical theory, as well as theory from other knowledges derived from outside of conventional medicine. But most of all she is guided by this woman in the unfolding circumstances of her singular journey to deeper knowledge and experience of her baby and herself.

If this suspension of judgment and use of the presentable/theoretical as a resource rather than an end is possible between nurses and patients, midwives and clients, why are judgment and the rigid spine of the presentable applied so differently in the relation between nurses and midwives? Why is there so little togetherness is their caring 'together'? It could be argued that the relation between the caregiver and patient/client, as compared with that between the nurse and midwife is qualitatively different. Perhaps in some ways it is, particularly if the caregiver understands herself to have authority and an advocate role as regards the patient's care based in knowledge of her, where relation between caregivers may be more tangled and ambiguous in terms of authority and appeals to hierarchy. In addition, to be nurse to a patient, or midwife for a client, allows one to behave within a professional persona that is useful and protective to both woman and caregiver in shaping their relationship. To encounter another caregiver, particularly one from outside of one's accustomed milieu, may cause concern that the professional persona is not adaptable to being cast in a new role for which one does not have a set script. Yet, the fundamental encounter with difference remains. The space of unknowing still hangs between the self and the other.

One possible means of filling this space is to draw on one's own identity by appropriating the other into a con-fusion that compares the other to the self and says you are creditable (or not) because 'you are like me' to such-and-such an extent. Another is to see the self and other as incommensurable and therefore view the other as unworthy of notice, or too alarming to contemplate. Neither approach accounts for difference; both seek to escape its frightening implications. The space between is then a vast, dead nothingness (Irigaray, 2002).

Here is where the individual's interior and the exterior resources may inhibit relation. When the interior knowledge and valuing of self is not well developed or is enmeshed with some meta-narrative of identity to the extent that the genuine self may not come easily to the fore, the confrontation with difference can be baffling, intimidating, and/or threatening. If added to this is a rupture in the expected or customary context and role, a feeling that trust in others' anticipated responses is betrayed, or that one is thrown off balance by unknown expectations, unspoken and pending in the shared space, then the response can be emotionally charged. As Løgstrup (1997) puts it: "One's expectation exposed through its manifestation, has not been covered by the other person's fulfillment of it. And it is this exposure which causes the encounter to erupt in moral reproaches and accusations" (p. 10). As has been shown in many ways in this study, these feelings of confusion, off-balance, comparison, annoyance, righteous indignation and threat do erupt between the midwife and nurse participants. How then are nurses and midwives to overcome such reflexive, defensive responses to one another when they occur? How can they find a way to care together *within*, not in spite of, their differences?

Reconciliation/Difference

The entrance into this mystery of difference in relation is sought and experienced between two individual selves. It cannot be otherwise without the distancing of generalization and assumption concealing one from another. It is not a transaction the basis of which is expectation and categorization of the other supported by comparison, carefully weighted and anticipated recompense, and the expectation of a power equally shared (even though this may actually occur); rather entrance into this mystery is by

means of opening and desiring a horizontal transcendence between self and other. Such transcendence is possible only through the open door of hospitality and welcome, the threshold of which is that space-between made alive through attentive, silent listening and looking towards the other in their alterity. Both the extending of welcome and the acceptance of hospitality are reconciliatory impulses because they open onto an ever new/renewed experience of relation. Might simple acts of welcome and hospitality break the constraints of meta-narrative and contextuality to alter and renew relationships between nurses and midwives?

To reconcile means to come together into, or to gain, relation in a new way. The implication of the word is that those being reconciled were not unknown to one another, but that their knowing has been deepened, refocused, illuminated in a radical and radicalizing way. It can mean new self-understanding as well as new harmony and compatibility with another. In lived experience with others reconciliation necessarily entails both. To understand another anew requires a shift in the self. In Roman Catholicism, reconciliation has a specific meaning, which is the renewal of a right relationship with God through self-examination, confession and absolution and the acceptance of God's ongoing love and grace. This in turn allows the one released into new relation to feel welcome to accept the hospitality of Christ in the Eucharist, the symbolic meal of communion and thanksgiving. In this communal meal the participants are both welcomed and welcoming, both host and guest. This is one illustration of the meaning-link between reconciliation, welcome and hospitality. It speaks of willingness to embrace the possibility of mutuality manifested in sitting down together and in the sharing of a meal with others that acknowledges the relatedness of participants in both

their shared humanity and in their unique differences. This recalls the very concrete inverse situation related by midwife Deanna, in Chapter Six, who spoke of being excluded by nurses in their sharing of tea and toast in the middle of a long and busy night.

With Self

If deeply at home in a sense of self, opening the hospitable doorway, seeking reconciliation in extending welcome need not constitute a fearful vulnerability. When nurses and midwives nurture their interior resources, that is, their selves as well as their being as nurses and midwives, they become not only stronger in the differences that distinguish them but also more wondering and respectful of the mystery of their own uniqueness. But this must occur not from an exclusionary, rigid dwelling in their professional identities, walled off from what is unlike them. Rather, this means opening first to the internal 'other' that is continually becoming (Irigary, 2002); that makes them unlike any other and lies beneath the professional persona giving it singular, evolving, personal strength and integrity. It also means being willing, as a part of this becoming, to explore feelings like anger, fear, jealousy, dislike or betrayal that may be aroused in the presence of another. This is an interior journey that promises both growing positivity and peace, allowing increasingly for openness and flexibility, freeing and clearing the self to focus with strength on those others one is with.

From a rootedness in self-respect, the self grows outward toward the other with interest and open to the possibility for mutual respect, allowing the questions raised by the mystery of alterity to water the roots of the self. This creates the possibility for more than simply tolerance of difference by providing the individual with an ever-expanding

shelter, an interior home from which to engage with it. In the realization of this possibility, conflict based in judgment, exclusion, and comparison leading to feelings of threat need not exist; rather there is an opening made onto the consequent opportunity to differentiate where true negotiation of difference is needed. Conflict as disagreement is inevitable in human interaction. But an 'allergic' response to difference (Barnett, 2005), viewing it as morally reprehensible, is the least life-giving, least fertile of its bases. Such judgment as the basis for conflict is violent and aggressive, seeking to erase the other in their alterity (Barthes, 1975). Non-aggressive conflict aimed at the positive transformation of a situation can be the instigating energy for dialogue, even consensus, and the discovery of synergy. From personal knowledge and strength, as described above, and resulting comfort with difference, disagreement can become encompassed within an extension of welcome, and a place made for such conflict at the table of hospitality.

The degree to which individuals know and love themselves, experience peace within themselves, is no doubt as varied as are the individuals. In the anecdotes and accounts of the dimensions of conflict between nurses and midwives in this study some variances are evident related to their self-confidence and self-esteem that seem to be based in the political and historical nature of the two professions and in the hospital context. Nurses must ostensibly take direction for the substance of their work from physicians. But in reality they work independently most of the time with direct influence on the health of patients in the unpresentable manifestations of nursing care. Nevertheless, they often feel unacknowledged for their work and its significance and, in some cases, may not acknowledge and value this work themselves. There is tacit, unexamined and disgruntled acceptance by nurses of the disempowering structures within

which they are located, the diminished regard with which they believe themselves to be held and, with which they sometimes hold one another (Roberts, 2000). Encounters with allied healthcare workers such as midwives, whose work seems to nurses to be what they themselves do are understandably confusing and threatening (see Chapter Five). Without more deeply inhering self-esteem it may be difficult for nurses to be hospitable towards midwives, who come into nurses' milieu with differing philosophies and approaches to the care of childbearing women.

By contrast, midwives, who operated independently outside of the established healthcare system until being regulated, have had to explain their work over and over, and in this articulation have developed a strong awareness of the meaning in what they do, why and for whom they practice. As many of the midwife participants in this study described, they have acted as political activists, public relations representatives, and apologists for their understanding of pregnancy, birth and belief in the strength and autonomy of women. This speaks not only of their courage and commitment to the women who desire their care; but also of the personal strength many of them have developed in confronting the inevitable condemnation that those who challenge accepted structures endure. In this regard it may be difficult for midwives to accept the welcome that comes from those within a social context by which they have felt judged and excluded. This said, the lived experiences of individuals in this study inevitably spoke of well developed as well as less developed self-esteem and self-knowledge among both nurses and midwives.

Just as their relationships with patients/clients are subject to the presentable and unpresentable, so is self-understanding. A presentable identity for the nurses in this study

is to be found in their dedication to caring, alignment with other nurses, with medicine and with the hospital as a dwelling place, as well as in the theoretical basis for their practices, all of which secures them a role as tenders and practical purveyors of scientific truth. For the midwives what might be considered a presentable identity is less easy to pinpoint, but perhaps it lies in the romantic image of a traditional, earthy, independent, wise woman who is unafraid to cross-fertilize knowledge paradigms and wears an intense commitment to women like a badge. In both cases these are effigies, bearing some resemblance, holding some key attributes, but not the individuals themselves. The unpresentable for nurses, midwives and all individuals is the mysterious nature of the becoming self, which shows in each caregiver in the unselfconscious, relational, caring acts with women and babies, matures there as in other relationships, but which is equally nurtured in solitary moments of honest reflection. "The human has to turn not only toward the outside but also toward the inside, on pain of losing its humanity. And a human's making cannot be only exterior, it is also interior" (Irigaray, 2002, p. 173). How can the growth and discovery of self be fostered? How can it be strengthened to blossom in the presence of difference and disagreement?

Irigaray (2002, p. 86-87) speaks of the conscious "return to oneself", "[a]dvancing toward what is most veiled in oneself," a "gesture that is most crucial in order for the [self] becoming to be fulfilled appropriately." She suggests that this becoming, this growth into the potential of our humanness, is "relation-with" our self as much as relation with the other and the world. In nursing epistemology reference is often made to Carper's (1997) model of the four patterns of knowing utilized by nurses in practice. Of the four (empiric, aesthetic, ethical, and personal knowing), Carper describes personal knowing as

the most essential to the relational work of nursing. She speaks of this knowledge of self as irrelevant to categories or labels, but as something actualized in being with others, dependent upon self-acceptance and self-respect as well as the willingness to live with ambiguity (difference) in self and others. Chinn and Kramer (2004) elaborate on Carper's discussion of what personal knowing is to describe ways of developing it through reflective journaling and practices such as meditation, which assist the nurse in self-exploration and deepened self-knowledge. Bergum and Dossetor (2005, p. 82-83), in their exploration of relational ethics in the context of healthcare, state that the first question of ethics is 'Who am I?' This on-going journey into knowledge of the self requires an "attitude of humility" that is not possible without being in relation with others, and yet is also not possible without self-exploration – relation with the self – in light of this relation with others. These authors suggest that to stop asking questions of the self is ultimately to diminish the effectiveness of one's practice and to jeopardize the safety of one's patients. Do we know how to be with our selves? Do we know how to nurture this in those choosing to become professional caregivers?

If it is imperative that inter-professional relationships be collegial – and it is – then the first step toward actualizing this mutual respect is to assist ourselves and one another in the work of self-respect, self-wonder, and humility. Those exterior resources that impinge upon and contextualize relation between professionals can be consciously shaped to support their self-esteem as the grounding for mutual respect. In formal educational settings, nursing and midwifery educators can model this for students in honest and appropriate self-disclosure, and encourage students to cultivate it in themselves through opportunities and assignments involving personal reflection and

existential exploration. Nurse managers can encourage this kind of self-care in their employees; and foster a moral space of thoughtfulness, honesty and mutual support in the places where nurses and others work. Likewise, midwives can support one another to encounter and nurture a deepening sense of self in order to better support the women who come to them, whether in group practices or informally with colleagues and loved ones. Equally wonderful might be transprofessional friendships and collegiality between nurses and midwives that make possible this mutual nurturing for personal growth. This ever deepening, renewing reconciliation of/with the self, illuminated by relation with the other, is an infinite way of being that doubles back upon itself, touches and moulds, at once supporting the other and the self; a chiasmic relation like that between mother and baby (Wynn, 1997).

With the Other(s)

I have spoken thus far of relation-with in terms of dyads: mother-baby, woman-caregiver, nurse-midwife, beginning with the self and the internal 'other.' As suggested above, our human being is in relation, we become more human in proximity with another and so it is between two where ethical relation begins (Bergum & Dossetor, 2005; Irigaray, 2002; Levinas, 1981). However, the reality of nurses' and midwives' work both separately and together is not only within dyadic relations. It is also 'political' in that together or with their patients/clients the effects of their relationships affect others who may or may not be in immediate proximity. The multiple dyads present at the time of birth intersect to form a relational matrix of exponential connections and reverberations, inhering in the particular place and time, but also extending beyond the space and temporality of the immediate. There are unseen others whose uniqueness contributes to

the present diversity. (This is true for all of us wherever we are situated in the shared economy of physical, earthly and social elements that sustain us.)

It is realistic and prudent for caregivers to consider relationships not only with those in immediate spatial proximity, but to open their concern in an awareness that includes others to whom they have responsibility. Here are some examples evoked in the participants' stories. For the nurse encountering the midwife and her client, their on-going relationship with one another is a profound component of the mystery that she may witness in their being. There is also, of course, the paramount relational between the woman and her baby. Connected with this is the relation that the woman and baby have with their loved ones and the loved ones' reciprocation. These become strains of relational colour, sound and texture that the nurse may open to, listen to and see without confining them to pre-given classifications and categories, acknowledging the inherent significance, care, and love in these relations. She may attune herself to them maintaining engagement that is respectful of the primacy of these pre-established bonds but ready to respond when the need for more embodied engagement-with summons her. Likewise, the midwife comes into a workplace where nurses assist and support one another, reliant on an appropriate distribution of workload and agreement based in the written and spoken systems and institutional guides that give some consistency to their practices. The midwife may find these relationships with friends and co-workers manifested as strongly held commitments and responsibilities meaningfully etched into the mystery of the nurse's being. Respectful of this when requiring the nurse's engagement, she may temper her request for help with welcome, clarity and consideration.

The responsibility within these interactions is not one-sided. It is, as Levinas (1981) says, "One-for-the-Other" (p. 135-140) across and between the dyadic relationships, but because there are always others beyond the dyad, the presence of a "third" who also calls for a response, "Justice is necessary" (Levinas, as cited in Derrida, 1999, p.30). Justice extends not only to the others in proximity, to the nurse and midwife and the immediate relational matrix. The necessity for justice calls for interest and concern to be extended out to unseen, 'distant others' (Barnett, 2005).

As both Levinas (1996) and Derrida (1999) explain, attention to justice presents a conundrum for a relational ethics that welcomes the other without demanding that the other be categorized (judged). An ethics before ontology must be based in the moral impulse that does not contextualize the other in this way (Levinas, 1997). However, justice requires consciousness, evaluation, comparison, and representation. How can nurses and midwives be responsible, open and present to the other(s) in immediate proximity and also responsible to distant others? This requires a living into the possibility of justice through reconciliatory being. We bring about justice through opening the place of mystery, the space-between, in which the other unfolds toward us and we toward them. This space and our listening within it allow the other to name themselves (Derrida, as cited in Barnett, 2005) and to reveal their self-understanding. This opening and listening is a reconciliatory act because in it we set aside our assumptions about the being of the other, which rise up like a mist before the other as the already-known hiding them from us. This 'mist' may be dispelled both by our surprise in the other's gift of themselves to us, and by a conscious commitment to listen for the other's self-naming. Such commitment to the other, and therefore also to self, contains, as Irigaray (2002) describes,

the potential to rebuild the world, to promote a radical equality through the embracing of that which is never equal or the same; difference.

Difference as perfectly incarnated in each person is absolute, infinite, and extends out to encompass all of human diversity (Irigaray, 2002; Levinas, 1981). In openness to it we encounter not just the other in immediate proximity to ourselves, but we begin to make space in our wondering for distant others in their radical alterity, recalled and beckoning like a promise in the mystery of the individual before us. The respect for all within the relational matrix of the place of birth, and the infinite value accorded to the mother-baby chiasm that is the beginning of our humanness-in-relation, of woman as the first to welcome with hospitality "par excellence" (Levinas,1969, p. 155), begins the work of reconciliation in us with distant others, other women and infants, humanity as other mothers' children. Justice can begin here.

Problem and Mystery Revisited

At the beginning of this chapter I suggested that solutions to problems may facilitate entry into and exploration of mystery. The problem of difference and the mystery of relation are inextricably linked. The solution to the problem of difference, stated simply, is to cease to experience difference as a problem. At one level this would require the inversion of Northern/Western Culture, and the ontological, epistemological, aesthetic and axiological assumptions that uphold it. However, by acting with faith that proximate action and present being can have global effect, and with thoughtful concern that personal experiences of relation are indeed political in their radiating effects, a space in which to reconcile with and embrace difference becomes evident.

Earlier, interior and exterior resources were identified as both able to support the life of relation and also, at times, consign it to death. The intentional strengthening of interior resources, those found by journeying into the mystery of the self, is ultimately the choice of the individual; but without this, much joy and 'bliss' (Barthes, 1975) are forfeited. However, fortunately, this strengthening evolves from relation with others the opportunity for which is infinite. Some ways to nurture interior resources were touched on above, but means to developing relation with the self are too vast in scope to explore here. Nevertheless, it is a beneficial and life-giving endeavour to be reconciled with the self; it is the first step in reconciliation with the world (Irigaray, 2002); the first ethical question (Bergum & Dossetor, 2005); and to pursue it could deeply enrich the relational work and being of nurses and midwives.

The border between the interior and the exterior is highly permeable. Relation with the other constitutes this 'border-land' as the nexus wherein the self engages with the world, the place where we meet the stranger, the wholly other, difference. All of our social structures, material and intellectual, are built upon relation (or its withholding). Using the framework for relational ethics from Bergum and Dossetor (2005), I explore here the criteria for collaborative healthcare practice as synthesized by Schober and McKay (2004) in order to rethink the exterior resources that impinge on the work of nurses and midwives together and point the way toward strengthening their relation in the 'border-land.' The ethically relational aspects within which Bergum and Dossetor (2005) frame their discussion are: mutual respect, relational engagement, embodied knowledge, and ethical environments.

Mutual Respect

Schober and McKay (2004) identify mutual respect and trust, autonomy, and assertiveness as key to the success of collaborative, interdisciplinary practice. Likewise for Bergum and Dossetor (2005) these qualities are central to ethical relation. Mutual respect begins simultaneously on the interior side of the border-land with self-knowledge, self-respect and an understanding of one's own personhood, and exteriorly in reaching outward in respectful relation with the other, who unknowingly teaches us who we are. Acknowledgement of this interdependence, which occurs both subtly and unconsciously, as well as consciously and practically in work together, assists us to recognize the personhood of others, their uniqueness and situatedness in relation with other others. Interdependence is the dance of mutually respectful autonomies; the acknowledgement that what we do independently affects one another (Bergum & Dossetor, 2005). This calls for a new understanding of power, not as control over the other, but as mutual power, involving both appropriate and respectful assertiveness and acquiescence. This is only possible where mutual respect has developed through mutual recognition of unique strengths and differences (Bergum & Dossetor, 2005). How can we come to know the other in busy practice situations in a way that allows this interweaving of selves in shared action and concern?

Relational Engagement

The answer to this question is in the interest, curiosity, wonder and communication that occur in relational engagement. That is, listening and response across the space between self and other that is not only dialogic, but also involves turning toward the other with wholeness and embodiment (Bergum & Dossetor, 2005).

Relational engagement can occur when two caregivers intentionally focus together, on/with one another, and/or with the patient/client to seek mutual action, or simply out of interest, to understand one another with mutual respect. Bergum and Dossetor (2005) suggest that relational engagement is both subjective and objective. It requires the ability to remain at once logical and feeling, acknowledging feelings toward the other within the self without letting them distort, cloud, and close off the relational space with judgments and assumptions. In this there is space for genuine conversation and dialogue, which allows for clear communication, questions and clarification, enhancing greatly the ability to cooperate and provide mutual support, all of which are criteria for true collaboration (Schober & McKay, 2004).

It is important that nurses, midwives and all healthcare providers, develop and practice this intentional relational engagement, with one another and with those in their care. Extended temporality and proximity can facilitate the deepening of relational engagement, but are not necessary conditions for it. An attitude of respect and attention, allowing the self to be fully present to the other, is immediate. Even in brief encounters relational engagement can have a profound and reconciliatory effect on those involved (Bergum & Dossetor, 2005). Viewed another way, this is the substance of the 'welcome' that opens us to others. When nurses and midwives encounter each other, even when both are busy managing many demands and responsibilities, there can be connection and respect in intentional relational engagement.

Embodied Knowledge

Schober and McKay (2004) identify shared competence among care providers of different professions as another important factor in the interweaving of collaborative

practice. This is defined as the acknowledgement that there are shared, overlapping and complimentary skills across disciplines and that no discipline or care provider "'owns' any set of skills" (p.11). Shared competence includes a valuing of shared learning and experience in the application of skills and knowledge, and the recognition that roles and responsibilities will vary depending on the needs of the patient/client and the practice setting. Shared competence then is influenced by the organizational structures in which it is enacted, but more particularly it is affected by the relational context of those working together and those for whom they care.

All of these aspects of shared competence have pointed relevance for the work of nurses and midwives together. Although they hint at the unpresentable, they seem to highlight the presentable in healthcare practice; that is, theoretical knowledge and technique. Interdisciplinary learning, both practical and theoretical, in formal and informal educational contexts can greatly facilitate a sharing of the presentable. However, it may be in respectfully engaged observation, emulation, and cooperation in the unpresentable practices of nursing and midwifery – the active, seamless integration of theoretical, personal and relational knowledge – that these caregivers can develop the greatest commitment to shared competence. In this we might see the flowing together of nurses' and midwives' intentional, embodied engagement with each other, as well as the embodied action of direct care with the mother and baby, their focus of mutual concern, carried out in the tacitly attuned ebb and flow if their shared involvement. This would require that difference and diversity in approach and philosophy be acknowledged with openness and respect.

Creating Ethical Environments

Bergum and Dossetor (2005) describe the space where ethical action can occur as not theoretical or artificially created. Rather it is found in the organically evolving interactions of our daily living and acting. The choices we make as autonomous selves create an environment that may or may not be conducive to ethical relation. When our choices and action are based in mutual respect, relational engagement, and embodied knowledge, ways of being that recognize our interdependence, the ethical environment may be enhanced not only for ourselves and those with whom we relate directly, but also for others. In collaborative practice this interdependence in decision-making becomes crucial and complicated. It is reflected in the shared responsibility and accountability that is integral to collaboration (Schober & McKay, 2004) and that require care providers to communicate willingly, share information transparently, and come to decisions that are mutually satisfactory for the patient/client as well as members of the healthcare team. How can agreement be reached when, as is sometimes the case between nurses and midwives, there are marked differences of interpretation and perception of risk? Who is responsible for mitigating this risk when it is identified?

Examples of such situations are presented in Chapter Six where nurses Theresa and Alison are confronted with babies born to midwife clients whose cardio-respiratory effort is not optimal at birth. Each nurse handled the situation and contributed to the ethical environment differently. Theresa intervened immediately; whereas, Alison held back somewhat anxiously, but ultimately trusted in the midwife's certainty and knowledge in the situation. In both cases the outcomes for the babies were positive. What

caused these different responses is not clear; however, these two examples provide a place from which to examine the issue of responsibility in the moral space of birth.

The midwife in each situation, rooted in the midwifery model which promotes informed choice and fiercely protects the mother-baby bond, trusted the woman, her client, to stimulate and rouse her infant in receiving it. Whereas the nurse in each scenario, practicing and analyzing the situation conscientiously according to perinatal nursing best practice guidelines, saw the infant as separate from the mother. Its cardio-respiratory effort did not meet normal physiologic parameters, and so it was judged to be in need of intervention. Both groups of caregivers responded responsibly to the situation within the thinking and contexts of their models of practice and good care. This demonstrates the complexity that Schober and McKay (2004) speak of in interprofessional practice situations.

Bergum and Dossetor (2005) suggest that openness to the experience of "mutual thinking" (p. 177) can assist in creating understanding and consensus that acknowledges differences and encompasses them within the shared space of dialogue, not as blockages in the path toward one another, but as part of the human terrain and sometimes as valuable vantage points for new insight. In order for mutual thinking to occur embodied relational engagement is necessary. Those involved must consciously remain attuned to one another's being in what happens "'between words' or in the 'way' one speaks" (Bergum and Dossetor, 2005, p.177). The quality of the living space between words, as well as the words themselves, contributes to the ethical environment of interaction and contributes to the development of trust. Such trust may be difficult to achieve in situations where the nurse and midwife are unknown to one another and have had little

opportunity to interact previous to a birth. However, by meeting with openness toward one another, and respect for the one another's commitment to the woman and baby in being present, an atmosphere of positive possibility is created.

This presence with the mother and baby is central to maintaining the moral space of birth. This means extending embodied relational engagement to them, and remaining attuned to the mother's responses and the baby's need for her. Apgar measurements[14] can be taken with the baby lying on its mother's body. Stimulation and free-flow oxygen can also be given to the baby there. However, if it is necessary to remove the baby from its mother to provide more involved resuscitation efforts, this too can be done in a way that intentionally takes her experience into consideration. The perceived necessity can also be communicated between caregivers respectfully and quickly if openness and positivity toward one another is present. Handling such a situation with respect can contribute to mutual thinking in which each caregiver acts responsibly and with understanding that from moment to moment one caregiver's initiative, understanding and skill may take precedence over another's.

Organizational environments and the relational ethics of leaders and managers can also influence the facility with which collaborative decision-making takes place between caregivers, as is evident by its absence in some of the conflictual anecdotes in this study. Schober and McKay (2004) identify smooth coordination of collaborative care as essential both to caregiver satisfaction and positive patient outcomes. In many of the anecdotes related in this study the responsibility for coordination of the care for

[14] Apgar measurements are taken based on the following five parameters: heart rate, respiratory effort, muscle tone, reflexes, and colour (indicating perfusion). Each parameter is rated on a scale of 0 to2 with a maximum score of 10 for the five parameters overall. These measurements are taken at one minute and five minutes following birth and at five minute intervals thereafter if the first two measures were below the normal range of 7-10.

individual women and babies is ambiguous. There is confusion regarding roles and responsibilities and the expectations nurses and midwives have of one another. In institutional environments there may be an over reliance on what is written and tucked away in policy manuals by those with the professional authority to affect the context of their interaction. At the same time, those who are employees of the institution, nurses, may be so accustomed to habitual and prescribed roles that they feel unprepared when confronted by difference in the midwife and her client. Respectful, collegial communication regarding expectations and contingencies between nurses and midwives, organized and encouraged by managers, may help to positively strengthen the web of relation in the workplace; particularly if attention is given to modeling relationally ethical ways of interacting. This includes opening the space for difference and for disagreement. In addition, meeting and talking away from the hospital environment, in friendly social contexts where the categorizing effect of professional roles does not interfere, might allow new ways of engaging more deeply with and understanding one another as whole persons (Lutes, 2002; McCallin, 2000).

The creation of ethical environments, of carrying and planting the seeds by which they can flourish in our words, actions and ways of being-in-relation, is closely linked to justice, to relational responsibility with distant others as well as with those in proximity. To take seriously the understanding that our being in everyday interactions contributes to recreating and reconciling the world is both humbling and life giving. This realization is especially significant for those who attend, are relationally engaged, at the time of birth.

The Common Ground

The 'common ground' that the nurses and midwives in this study share is acknowledged as familiar to both groups; and yet they traverse it on different paths, which at times cross, run parallel, and diverge. This ground is the primary human terrain of mother-baby-birth; the sacred ground of our being-in-relation. Birth is altogether mysterious, the most profound sign of the mystery of relation. Like death, birth is an event that we all have in common as one boundary in the circumscription of our lives, yet of which we can never relate our experience. Others, into whose community we are born as ineluctably unique, radical in our difference and indefineability, must witness and remember its significance for us. As midwives and perinatal nurses we are immensely privileged to be witnesses, to have attendance and facilitation of birth as our professional work. It is rare work in which there is freedom to offer absolute hospitality to the mother who comes to us as concretely embodied relation, and then to welcome the other who comes from her as her guest and ours. But this tiny person who slips out without prejudice, quintessentially vulnerable, is also embodied grace and hospitality, the proof of reconciliation and hope. In proximity to mother and baby at birth we are guests and hosts together, given a sign of welcome into possibility and new relation.

Birth has the power to be transformative for those who witness it. It is raw and wholly human in nature and in this escapes the definitions and analysis with which it is inscribed in the presentable language of theory. Birth is a sign of the inescapable, inseparable unity of body, mind, emotion, and spirit as the fruit of human need, love and relation. In this sense it is unpresentable in its incomprehensibility; a phenomenon that must be witnessed and experienced to be understood, and understood not only with the

intellect. Once experienced, for those who are receptive, birth is indelible in its transformative effect. This is not only so for the parents, but also for those who assist and share in the event. Nurses and midwives who share in it and know its power could allow the significance of birth and what it illuminates of our humanity to transform their relation to one another. To do otherwise, to deny our relatedness in the presence of birth, is to violate the moral space that is created by it.

This privilege that we, nurses and midwives, share as witnesses of birth does not signify our sameness, but rather a potential bond of mutual understanding, the jewel of a mystery that we may wonder at together, perhaps eagerly describe for one another. We enter into the space of birth in our difference and witness from our different vantages. From there we can look across into one another's faces and look together toward the woman and her baby. It is our differences that are most fertile. They are the endless source of curiosity, interested engagement, dialogue, listening, disagreement and discovery that seed the common ground between us making it fecund soil for our mutual growth.

CODA:

FUTURE INQUIRY

This research inspires further questioning and opens many paths for future dialogue and research. I will end the dissertation with some thoughts in this regard. The comprehension of difference, ethical relation and the meaning of childbirth as the site of hope and commonality are highly relevant to the global community as well as to interprofessional teams of healthcare providers.

Themes addressed in the study can be further explored through phenomenological writing. One of these is that of birth as the common ground or as a 'commons.' That is, a space that belongs to all and is shared by all regardless of status and designation. What does this shared space mean to parents and families, or to caregivers? What meanings regarding this shared space determine who is included? The answers to such questions may be both personal and political. The potential for birth – natality – to bring us together in hope and nurturance may have profound implications for people and the planet.

Another theme that calls for additional exploration through writing is that of the dimension of loving relation between the caregiver and patient/client. What is the emotional and embodied experience of this relation? What is the experience of opening such intense relation up to share it with other caregivers, or perhaps to relinquish it to them? What is it like to be excluded from this relation?

The phenomenon of difference in the context of perinatal care suggests many avenues for research. For example, what differences exists among women who choose midwifery care and those who choose care by physicians and nurses? What are women's

understandings of themselves, pregnancy, childbirth and parenting that guide them in making these choices? What is the experience for nurses and midwives of establishing relationships with women and families who differ in significant ways from conventional social norms and expectations due to sexual orientation, ethnicity, disability, beliefs or values?

The experience of difference and of finding mutual understanding within interprofessional healthcare teams is also a fertile area for exploration. How do professional philosophies and personal understandings of professional identity shape the relationships between physicians and midwives or physicians and nurses? What is it like to work interprofessionally when teams are small and individuals must work within expanded roles and responsibilities as those who practice in small rural hospitals must?

All of the topics suggested here for future research are based in relation and the ethics of relation. Providing healthcare is necessarily relational work, so as we prepare student nurses and midwives a pedagogy of relational ethics is needed. How do we evoke the practice of ethical relation in ourselves and others, our students and those we work with or mentor? What does it mean to be in ethical relationship with them? The comprehension and negotiation of difference as well as sharing in enlivened common ground cannot occur without the praxis of ethical relation.

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APPENDIX A

PARTICIPANT PSEUDONYMS

Nurses	Midwives
Alison	Darya
Deborah	Deanna
Jenna	Hilary
Kathleen	Iris
Nancy	Judith
Nicole	Lauren
Rhonda	Leona
Roxanne	Marianne
Theresa	Pamela
Vivian	Sheila
	Val

APPENDIX B

INFORMATION LETTERS AND CONSENT FORMS

Information Letter for Nurses and Midwives

Consent to Participate: Individual Interview(s)

Consent to Participate: Close Observation

Information Letter for Women and their Family/Friends Who are Present During Observation

Consent to Participate: Presence During Observation

Information Letter for Nurses and Midwives

Research Study Title: Seeking Common Ground: Experiences of Nurses and Midwives

Investigator: Lela Zimmer, PhD (Nursing) Candidate
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Purpose of this Study
The purpose of this study is to learn about nurses' and community midwives' experiences when they care for childbearing women. This study is part of my doctoral work in nursing.

Background
Nurses and midwives both take care of pregnant and birthing women and their babies. Though many of their skills and tasks are the same, there are also differences in how they care for women. Now that community midwives are registered and have hospital privileges they are coming into contact with hospital nursing staff more often than before. I would like to learn more about the ways in which nursing and midwifery are the same and different. I would also like to learn about how this affects their work together at times when midwives bring women into the hospital. My research will help both nurses and midwives to know what strengths they have to offer one another and how they can work together best. For this reason I would like to talk to nurses and midwives about 1) their experiences with childbearing women and 2) their experiences with one another. I would also like to observe nurses and community midwives when they work with women.

Procedures
I am asking nurses and community midwives who (1) have the experience of caring for pregnant and birthing women, and (2) have worked together in the hospital to care for a midwife's client, if they would like to be a part of this study.

Audiotaped Interview: If you take part in this study you will be asked to talk with me about your experience of caring for childbearing women. You will also be asked to talk about your experience of caring for women with a nurse or community midwife. I will ask questions such as: "What are some experiences of caring for women that stand out for you?" And "What are some experiences you have had interacting with community midwives / nurses in the hospital when caring for women?" These conversations will last 1 - 1 ½ hours. It is possible that we will talk a second time. This second conversation will also last 1 - 1½ hours. Our total conversations will take no more than 3 hours. These

conversations will take place in your home or workplace. If a place other than your home or workplace is better for a meeting then this will be arranged. Our conversation(s) will be audiotaped. A typewritten copy of what we say on the audiotape will be made. If you would like to participate, you will be asked to sign a consent form before we talk.

Close Observation: I am also asking nurses and community midwives who would like to participate in this study if they would like to be observed when they work with women. If you agree to let me observe you I will spend no more than two 8-hour periods with you in your place of work. I will not be present if any woman you are caring for does not want me to be there. The total time you will be observed is no more than 16 hours. I will take some notes during observation. These will be written up in detail afterward. You will be asked to sign a separate consent form if you agree to be observed as part of the study. You may participate in the interview only if you wish.

Risks and Benefits

There are no known risks to you if you take part in this study. There are also no direct benefits. However, some people may find the time to talk about personal experience beneficial. Results from this study may help to improve nurses' and midwives' practice. They may also help nurses and midwives to work together better in caring for midwifery clients who come into the hospital.

Confidentiality

If you decide to be in this study **your name will not appear** in any written or audiotaped materials related to the study except the consent form(s). You will be given a number and a false name that will be used in materials related to the study. All consent forms, numbers, and false names will be stored in a locked cabinet. All other materials including the audiotapes, typewritten copies of what is said, the notes taken during observation, and the writing from these notes will be kept in a different locked storage area. Only I (the investigator) will have access to these locked places. The findings from this study may be published or presented at conferences, but your name and anything that could be used to identify you will not be used.

Freedom to Withdraw

If you choose to be in this study you are free to drop out at any time. Dropping out of the study will not result in any harmful or unpleasant consequences to you.

Additional Contacts

If you need to talk to someone about this study, you may call my supervisors, or me. My phone number is (250) 960-6630 and my email address is zimmerl@unbc.ca. My supervisors' phone numbers appear at the beginning of this letter. If you have concerns while this study is in process you may also speak with the ombudsman for your local hospital or health region.

CONSENT TO PARTICIPATE: Individual Interview(s)

Research Study Title: Seeking Common Ground: Experiences of Nurses and Midwives

Investigator: Lela Zimmer, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (BC): (250) 960-6630
Email: zimmerl@unbc.ca

Supervisors: Dr. Vangie Bergum
Faculty of Nursing,
University of Alberta
Phone: (780) 492-6676

Dr. Brenda Cameron
Faculty of Nursing
University of Alberta
Phone: (780) 492-6412

Part 2 (to be completed by the research participant):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

CONSENT TO PARTICIPATE: Close Observation

Research Study Title: Seeking Common Ground: Experiences of Nurses and Midwives

Investigator: Lela Zimmer, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (BC): (250) 960-6630
Email: zimmerl@unbc.ca

Supervisors: Dr. Vangie Bergum
Faculty of Nursing,
University of Alberta
Phone: (780) 492-6676

Dr. Brenda Cameron
Faculty of Nursing
University of Alberta
Phone: (780) 492-6412

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Information Letter for Women and their Families/Friends
Who are Present During Observation

Research Study Title: Seeking Common Ground: Experiences of Nurses and Midwives

Investigator: Lela Zimmer, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (BC): (250) 960-6630
Email: zimmerl@unbc.ca

Supervisors: Dr. Vangie Bergum
Faculty of Nursing,
University of Alberta
Phone: (780) 492-6676

Dr. Brenda Cameron
Faculty of Nursing
University of Alberta
Phone: (780) 492-6412

Purpose of this Study

The purpose of this study is to learn about nurses' and community midwives' experiences when they care for women who are having babies. This study is part of my doctoral work in nursing.

Background

Nurses and midwives both take care of pregnant and birthing women and their babies. Though many of their skills and tasks are the same, there are also differences in how they care for women. Now that community midwives are registered and have hospital privileges they are coming into contact with hospital nursing staff more often than before. I would like to learn more about the ways in which nursing and midwifery are the same and different. I would also like to learn about how this affects their work together at times when midwives bring women into the hospital. My research will help both nurses and midwives to know what strengths they have to offer one another and how they can work together best. For this reason I would like to talk to nurses and midwives about 1) their experiences with women who are having babies and 2) their experiences with one another. I would also like to watch them at work with women.

Procedures

I am asking nurses and community midwives who 1) have the experience of caring for pregnant and birthing women, and 2) have worked together in the hospital to care for a midwife's client, if they would like to be a part of this study. Your nurse / midwife has chosen to be in this study. She has also said that she would like to be observed when she works with women. She has agreed to let me observe her for no more than two 8-hour periods in her place of work. You are here during one of these times. I will take some notes as I watch your nurse / midwife work. These will be written up in detail afterward. I will not record your name in these notes. The notes are about how your nurse / midwife works. I will not be present while she spends time with you if you do not want me to. If you are willing for me to be present I will give you a consent form to sign. I will leave

the room at any time if you ask me to. The total time that you will be observed is the length of time your nurse / midwife spends with you at this visit.

Risks and Benefits

There are no known risks to you if you take part in this study. There are also no direct benefits. Results from this study may help to improve nurses' and midwives' practice. They may also help nurses and midwives to work together better in caring for midwifery clients who come into the hospital.

Confidentiality

If you decide to be in this study **your name will not appear** in anything written related to the study except the consent form. You will be given a number and a false name that will be used in materials related to the study. All consent forms, numbers, and false names will be stored in a locked cabinet. All other materials including the notes taken during observation and the detailed writing from these notes will be kept in a different locked storage area. Only I (the investigator) will have access to these locked places. The findings from this study may be published or presented at conferences, but your name and anything that could be used to identify you will not be used.

Freedom to Withdraw

If you choose to be in this study you are free to drop out at any time. Choosing not to let me observe your nurse / midwife while she is with you will not change the care she gives you or result in any harmful or unpleasant consequences to you.

Additional Contacts

If you need to talk to someone about this study, you may call my supervisors, or me. My phone number is (250) 960-6630 and my email address is zimmerl@unbc.ca. My supervisors' phone numbers appear at the beginning of this letter. You may also speak with the patient ombudsman for your local hospital or health region if you have concerns about this study while it is in process.

CONSENT TO PARTICIPATE: Presence During Observation

Research Study Title: Seeking Common Ground: Experiences of Nurses and Midwives

Investigator: Lela Zimmer, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
Phone (BC): (250) 960-6630
Email: zimmerl@unbc.ca

Supervisors: Dr. Vangie Bergum
Faculty of Nursing,
University of Alberta
Phone: (780) 492-6676

Dr. Brenda Cameron
Faculty of Nursing
University of Alberta
Phone: (780) 492-6412

Part 2 (to be completed by the research subject):

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.	Yes	No
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee ***Date***

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

APPENDIX C

RECRUITMENT MATERIALS

Template for a Covering Letter to Hospital Directors of Nursing

Covering Letter to BC Midwives

Advertisement for Nurses to be Posted in Hospitals

Advertisement for Midwives to be Placed in the Midwifery Association of British Columbia Newsletter

Reply Card for Nurses and Midwives

[Current Date], 2000

_____, Nurse Manager,
_____Hospital,
_____, BC

RE: Research Study – "Seeking Common Ground: Experiences of Nurses and Midwives"

Dear _____,

Thank you for speaking with me on _____ regarding my nursing dissertation research project. I sincerely hope that nurses from your hospital will be interested in participating in this study. As we discussed, nurses who wish to be a part of the study are being asked to participate in one-on-one interviews. In addition, if some nurses were willing, I would like to observe them during their work in caring for childbearing women.

I am attaching some additional information regarding the study. Please find enclosed samples of the following documents: information letters for participants (nurses and midwives), and patients who may be present during participant observation; consent forms; an advertisement to be posted in the hospital in an area frequented by perinatal nurses; and the reply card by which nurses can contact me. I will contact you again by telephone once you have had an opportunity to read over these materials. At that time I will be happy to answer any questions you may have. Perhaps we can also discuss the possibility of my meeting with staff nurses working in the perinatal area in your hospital in order to introduce the study to them and answer their questions. If you wish to speak with me at any time please do not hesitate to contact me. My phone number at the University of Northern British Columbia is (250) 960-6630; and my email address is <zimmerl@unbc.ca>. I look forward to speaking with you again.

Yours sincerely,

Lela Zimmer, RN, PhD (Nursing) Candidate,
Faculty of Nursing, University of Alberta,
C/o Nursing Program,
University of Northern British Columbia,
3333 University Way,
Prince George, BC, V2N 4Z9
Phone: (250) 960-6630
Email: zimmerl@unbc.ca

[Current Date], 2000

Dear BC Midwife,

Please find enclosed an information letter regarding a research project I am conducting as part of my doctoral studies in nursing. The study involves community-based midwives and perinatal nurses as participants. Enclosed also for your convenience is a reply card and an addressed, stamped envelope that you can send to me should you wish to participate in the study or want more information.

Thank you for taking the time to read through this information.

Sincerely,

Lela Zimmer, RN, PhD (Nursing) Candidate
Faculty of Nursing, University of Alberta
C/o Nursing Program,
University of Northern British Columbia,
3333 University Way,
Prince George, BC, V2N 4Z9
Phone: (250) 960-6630
Email: zimmerl@unbc.ca

Needed: Perinatal Nurses
For Participation in a Qualitative Research Study

Title of the Project: **Seeking Common Ground: Experiences of Nurses and Midwives**

Investigator: **Lela Zimmer RN, PhD (Nursing) Candidate,**
Faculty of Nursing, University of Alberta

Purpose of this Study: To learn about nurses' and community-based midwives' experiences of caring for childbearing women. I would like to learn more about the ways in which nursing and midwifery are similar and different. I would also like to learn about how this affects nurses' and midwives' work together at times when midwifery clients come into the hospital. My research will help both nurses and midwives to know what strengths they have to offer one another and how they can work together best. This study is part of my doctoral work in nursing.

Participant Interview: As part of this research I would like to talk to perinatal nurses about the following: (1) their experiences with childbearing women, and (2) their experiences with community-based midwives in the hospital setting.
Participant Observation: I would also like to observe some perinatal nurses in their work with childbearing women.

If you are interested in participating or would like more information, please contact me in one of the following ways:

Reply card and stamped envelope (please see below)
Email: zimmerl@unbc.ca
Phone: (250) 960-6630

Needed: Community-Based Midwives

For Participation in a Qualitative Research Study

Title of the Project: Seeking Common Ground: Experiences of Nurses and Midwives

Investigator: Lela Zimmer RN, PhD (Nursing) Candidate,
Faculty of Nursing, University of Alberta

Purpose of this Study: To learn about nurses' and community midwives' experiences of caring for childbearing women. I would like to learn more about the ways in which nursing and midwifery are similar and different. I would also like to learn about how this affects nurses' and midwives' work together at times when midwifery clients come into the hospital. My research will help both nurses and midwives to know what strengths they have to offer one another and how they can work together best. This study is part of my doctoral work in nursing.

Participant Interview: As part of this research I would like to talk to community-based midwives about the following: (1) their experiences with childbearing women, and (2) their experiences with perinatal nurses in the hospital setting.
Participant Observation: I would also like to observe some community-based midwives in their work with childbearing women.

If you are interested in participating or would like more information, please contact me in one of the following ways:

Email: zimmerl@unbc.ca
Phone: (250) 960-6630
Mailing Address: Lela Zimmer, c/o Nursing Program
University of Northern British Columbia
3333 University Way
Prince George, BC, V2N 4Z9

Reply Card

Title of the Project: Seeking Common Ground: Experiences of Nurses and Midwives
Investigator: Lela Zimmer RN, PhD (Nursing) Candidate,
Faculty of Nursing, University of Alberta

___ I am interested in participating in your study.
___ I would like more information.
Please indicate how you would prefer to be contacted.
Name: _____
Phone: _____Best times to call_____
Email: _____
Address: _____