

## Women's Experiences of Consultation: Negotiating Conflicting Models of Birth

### *Les expériences de consultation des femmes : négociation de modèles de naissances en conflit*

Beth Murray Davis, RM, MA

#### ABSTRACT

The purpose of this study was to understand how midwifery client experiences are affected by interprofessional interactions during consultation between physicians and midwives. Ten midwifery clients from Southern Ontario who had experienced at least one consultation during their midwifery care participated in semi-structured interviews. The findings from the interviews suggest that women experience a conflict between biomedical knowledge and embodied knowledge, and between the hierarchy of physician-centred care and woman-centred care during the act of consultation. The interviews demonstrate that divergent professional philosophies may represent a significant barrier to interprofessional practice.

#### KEY WORDS

*models of practice, woman-centred care, interprofessional relations*

#### RÉSUMÉ

Le but de cette étude était de mieux comprendre comment les expériences des femmes qui utilisent les services sages-femmes sont influées par les interactions interprofessionnelles lors de consultation entre médecins et sages-femmes. Dix clientes de pratique sage-femme du sud de l'Ontario, qui avaient vécu au moins une consultation lors de leurs suivis sage-femme ont participé à des entrevues semi-dirigées. Les résultats de ces entrevues suggèrent que lors de la consultation les femmes vivent un conflit entre le savoir biomédical et le savoir incorporé, ainsi qu'entre la hiérarchie des soins centrés sur le médecin et les soins centrés sur la femme. Les entrevues démontrent que les philosophies professionnelles divergentes peuvent représenter un obstacle à la pratique interprofessionnelle.

#### MOTS CLÉS

*modèles de pratique, soins centrés sur la femme, relations interprofessionnelles*

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#### INTRODUCTION

In the time since the regulation of midwifery in Ontario in 1994, the relationships between midwives and other health professionals have evolved. Immediately following regulation, similar to other new professions, midwives focused on defining and developing their own professional boundaries rather than considering options for blurring professional lines.<sup>1</sup> The professional

practices of midwives, nurses and physicians were more aptly described as "parallel" rather than "collaborative".<sup>2</sup>

However, midwives cannot exist in isolation. They need to interact with other health professionals during the provision of care. This coordination is part of midwifery's mission of serving women and acting in their best interests. It is also the basis for the

midwife's scope of practice, which begins with low risk obstetrical and newborn care. If a midwifery client's pregnancy, birth and postpartum course are uncomplicated and remain 'low risk,' the only health care professionals that the woman will see will be her midwives. However, if a woman develops clinical concerns which are beyond the low-risk sphere, consultation, or referral, by the midwife and possibly a transfer of care to a specialist such as an obstetrician or a paediatrician may be required.<sup>3</sup>

Midwives interact with other health professionals whenever a consultation or referral is required. A consultation occurs when one health professional involves another health professional in the care of a patient, and often involves referral from a primary care provider to a specialist. Such is the case when a midwife, as the primary caregiver, consults with an obstetrician or paediatrician. This act of consultation across professions is one aspect of interprofessional practice.

Interprofessional maternity care involving midwives has garnered significant attention in recent years in response to the imminent obstetrical crisis.<sup>4</sup> Due to the declining number of general physicians providing obstetrical care, the difficulty in recruiting and retaining obstetricians, and the small number of midwives, many women in Ontario are experiencing decreased availability of essential maternity services.<sup>5</sup> Subsequently, both Federal and Provincial task forces have been created to examine this concern.<sup>6</sup>

The discourse of interprofessional practice suggests that it will enhance patient care and improve the allocation of health care resources. These two proposed benefits are cited as justifications for government funding and policy in Canada and in countries such as the United Kingdom, the United States and Australia.<sup>7-9</sup> However, this strongly-held assumption of improved patient care through interprofessional practice has not been fully considered. There is a limited understanding of how the experience of a patient is shaped by interprofessional interactions.

Most of the evidence gathered to date on interprofessional practice has focused on the health care professionals themselves, and has failed to evaluate patient outcomes.<sup>10</sup> This argument is supported by a systematic review by Zwarenstein et al., which concluded that there was insufficient evidence that interprofessional practice has any beneficial or negative consequences for patients.<sup>11</sup> D'Amour and Oandasan asserted that the absence of research involving patients has to do with researchers not perceiving patients to be participants in interprofessional care.<sup>9</sup>

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Further, the research on how patients feel about interprofessional practice has been predominately quantitative in nature which may have limited ability to provide an in-depth understanding into a person's lived experience. For example, most studies attempting to investigate patient experiences use methods such as a post-visit survey.<sup>12,13</sup> This research may have several shortcomings, eg. most of the studies have a limited number of outcomes, and those outcomes which are assessed have been selected based on convenience of questioning rather than on a theoretical assessment of interprofessional practice. For example, "wait-times" have been a common focus in patient outcome studies.<sup>14</sup> Schmitt argues that although wait times are a significant factor in patient satisfaction, and may be convenient for purposes of sampling, they may have little relevance to interprofessional practice.

With regard to women's experiences of maternity care, a relevant population of patients or clients who have experienced interprofessional interactions have not been studied. For example, a large Canadian research project was conducted to examine interprofessional practice in maternity services. One part of this project involved Canadian mothers who participated in focus group discussions about primary care.<sup>6</sup> However, none of the mothers were aware of, nor had been a part of interprofessional interactions during their maternity care. Thus, the findings become simply speculative about what the

anticipated benefits and disadvantages of interprofessional practice in maternity care might be. As a specific population, midwifery clients have not been studied, despite the fact that midwives engage in interprofessional interactions with physicians and nurses on a regular basis.

## OBJECTIVE

The goal in conducting this research was to understand the experience of midwifery clients during the every day act of interprofessional consultation. Rather than exploring this issue through the perspective of the health professionals, or through patient 'outcomes,' the experiences of women using midwifery services during the everyday process of consultation have been highlighted.

## METHODS

This research interprets midwifery client experiences through a qualitative, critical feminist lens. This methodology was used because of its ability to provide insight into the human experience by providing contextual information and by focusing on everyday experiences rather than a so-called 'objective' truth.<sup>15</sup> In this way the experiences of midwifery clients could come to the forefront of the research.

The study was approved by the University of Toronto Research Ethics Committee. Data was collected between August 2005 and January 2006. Written consent was obtained from all participants.

A convenience sample of ten midwifery practice groups in South Western Ontario agreed to post advertisements for recruitment of midwifery clients in their clinic. Inclusion criteria for participation required that the woman had experienced at least one consultation with another health professional during her midwifery care. Midwifery clients interested in participating contacted the researcher directly. The women were selected on a first come, first serve basis until theoretical saturation occurred.

The ten women who participated in the interviews came from a variety of geographical areas in Ontario, and they ranged in age from 24 to 39 years. Five of

the women were having their first baby. Two of the women had previous children but were having their first experience with midwives, and the remaining three women had experienced midwifery care in previous pregnancies. Four of the midwifery clients had experienced more than one consultation during their care.

The midwifery clients participated in semi-structured, in-depth interviews. The interview questions were informed by relevant literature, but were left open-ended to allow for rich description from the women. The interviews were audio taped and transcribed. Participants reviewed the transcripts to ensure they were an accurate representation of their interview. Thematic analysis was used to code the transcripts as described by Ritchie and Spencer.<sup>16</sup> Core consistencies and meanings were identified from the material and used to generate recurring themes.<sup>17</sup> Quotations have been included to maintain the woman's standpoint throughout the findings, but pseudonyms have been used.

## RESULTS

The presence of a physician-centred hierarchy and the experience of woman-centred care are two central themes that arose which influenced the women's perceptions of interprofessional consultation.

### *Hierarchy of Physician-centred Care*

Following a consultation for a vaginal breech delivery Cathy described her perception of the role of the obstetrician in shaping her labour experience:

*As soon as she [the obstetrician] walked in, the lights went on, the lighting got erased and it was always control. And everybody kind of hushed when she walked in and stepped away as she came up to the bed.*

Cathy found the presence of the physician-centred model of care to be in opposition to the model of care demonstrated by her midwives:

*There is not one health professional in that place that did not have my highest good in their mind. But, what that means in their minds versus in my mind could be as different as night and day. And the fact is that this*

*whole myth is based on fundamental difference and disempowerment. There is no way that you could be in a hospital and not be disempowered because of the way it is set up. And there is no way you could be disempowered with a midwife, if you are just with a midwife because the whole system is geared for empowerment.*

Georgia, who had an obstetric consultation following prolonged, prelabour rupture of membranes described a similar power imbalance centred around the physician:

*The whole idea of power and balance, the whole morning set it out perfectly. I met my midwife and we waited for the obstetrician to come out of a C-section. Sitting around waiting for the important person to come and make the decision... There didn't seem to be any tension [between the midwife and the obstetrician], but there seemed to be a definite power imbalance.*

Veronica, who developed an infection during her labour and required antibiotic treatment which her midwives could not prescribe also noted the presence of a hierarchy:

*Once the consultant offered the treatment, there wasn't any discussion about whether or not it was a good idea or whether or not we would choose that once the consultant had given or made the recommendation. There was a hierarchy there, but it was respected.*

Fiona described in her interview how both she and her midwife were disempowered during her labour due to one particular physician who ignored their requests. She attributed the hierarchy of roles which gave the physician control over her experience to the personality of one, individual physician:

*I think it was true that it came down to the personality of the obstetrician. And again, hearing the feedback from the nurses, this obstetrician does not work collegially with any of the other health professionals. I think it really came down to an issue of personality and self-conceptions about the role. She [the*

*obstetrician] is the one that has not really ever demonstrated functioning well with the team.*

Some of the women described how they advocated for themselves in the midst of the physician-centred care. This advocacy often came in the form of facilitating communication between physician and midwife. One midwifery client who was seeing an obstetrician for a series of consultation appointments found that there was poor communication between the consultant and her midwives. The two professionals were not interacting through written letters or telephone calls. The client went so far as to pick up copies of her records and drive them back and forth from one office to the office of the other health professional. She stated:

*I felt as though it was up to me to integrate all my different health care professionals, and no one was going to do it for me.*

Several women articulated that the hierarchy of the physician-centred model was a significant issue in their decision-making about choice of birthplace. For example, Martha's midwives had privileges at two hospitals. She ended up choosing one hospital over the other following a negative experience during a consultation early in her pregnancy:

*My conclusion from all of this, as a consumer, is that, although my experience wound up being a very positive one, it is unfortunate that the poor working relationship between the hospital and my midwives caused me to have to travel to another city to delivery my baby.*

Ellie's midwives also had privileges at two hospitals. One hospital required a transfer of care from the midwife to the obstetrician for epidural pain relief, while the other hospital did not. Ellie knew that she wanted to have the option of pain medication in her labour, yet she did not want to be put in the position where she would be required to choose between having a midwife or having pain medication:

*I felt much more comfortable going there to that hospital, because obviously they have the same*

*philosophy about letting women have input into their care, which is what I was looking for. My fear was if I had to go to the other hospital that all of a sudden all of those choices I had made would be taken away from me, and it wouldn't be a positive experience. It would be a frightening experience.*

#### *Women-centred Care*

Several of the women interviewed experienced consultation processes which were more egalitarian, involving the physician, the midwife and the woman as shared decision makers.

Nina had a Caesarean section due to concerns about her baby's well-being that arose during her labour. She described her impression of how her midwife and the obstetrician interacted after the decision was made to have a Caesarean:

*I was really impressed with how things happened. It's funny, it's like staying in a good hotel. You don't even know how things get done, but they did. My midwife just made things happen for me.*

Similar to Nina's experience, Nicole described how during her consultation process, the midwife attempted to maintain a woman-centred birth experience through advocacy for her choices. Nicole had a Caesarean section in her first pregnancy and after much consideration of the unique circumstances of her current pregnancy, she decided near the end of her pregnancy that she would prefer another Caesarean section rather than attempting a vaginal birth. She described a model of care that opposes the experiences of Cathy, Georgia and Fiona presented earlier:

*The relationship between the midwife and the obstetrician is very important in terms of being listened to as a patient. The obstetrician has met me once so they can do the professional assessments, but they don't know me personally. And in that scenario, what the patient says isn't necessarily given quite the same weight. Whereas because the midwife knows the person, knows their background, knows where they are coming from and knows what their knowledge base is then they will give different weight to what they say. My midwife was amazing at facilitating things*

*with the obstetrician. It was very reassuring. I didn't feel as if I was being shuffled between two different care scenarios. If they did not work well together, my decision would have been the same, but my anxiety about the decisions would have been significantly greater. Just knowing that they knew each other, that they worked well together, it was very reassuring.*

Virginia's birth story provides a third example of the realization of a more woman-centred model of birth. Her birth involved a post-dates induction of labour and slow progress in the first stage of labour. Finally, after many hours, she had a Caesarean section due to slow progress and as she described it, "some concerns about the baby's heart rate". Her midwife worked in a community where midwives are able to administer oxytocin and epidurals with an order from a physician. Therefore, an order was obtained from the physician to begin the oxytocin induction, and the midwife remained the primary care provider. Virginia described how the midwife continued to discuss her labour with the obstetrician throughout the day in an informal way. Yet, a formal transfer of care did not occur until the Caesarean was needed. Virginia was also happy that much of these discussions between the midwife and the obstetrician took place in front of her so that she was able to be fully informed of what was going on and was able to participate in decision making. She describes how these interactions took place:

*At the point when my midwife and I discussed that I would be induced that day, I believe that she went and discussed [this] with the obstetrician and we decided together. It was a mutual thing. We were on the same page, so we proceeded from there. When things weren't progressing as we would like to have seen, there was more consultation between the two. When [the midwife] left the room, she would always inform me as to where she was going, what she was discussing with the obstetrician and then return to tell me what had transpired. Also, there was a lot of consulting going on in front of me [and] with me and I was in the room. I really enjoyed that experience because I felt that there wasn't anything that couldn't be discussed in front of me. The rapport between [the midwife and the obstetrician] was very positive and agreeable.*

When Virginia was asked if this style of decision making had any influence on her care she responded:

*Absolutely! I think it is a stressful enough scenario... when you know your baby is showing signs of stress and I can't even imagine how much more stressful it would have been if there had been disagreements between [the midwife and the obstetrician], or if there was any sense of, well, you know, "I'm in charge here." There wasn't any of that. I had confidence in my decisions. I felt that when the decision came to having the Caesarean, having the two professionals with the same opinion, I mean really, I had the utmost confidence in the decision that I made. I have no doubt that we did the right thing.*

## DISCUSSION

This research began from a desire to understand the everyday experience of midwifery clients during the process of consultation or referral. The interviews with midwifery clients suggest that some women experience a conflict between the hierarchy of physician-centred care and woman-centred care during the act of consultation. These tensions appear to arise when two distinct models of care converge during interprofessional consultation. The two models are the medical model and the midwifery model of care. These different models arise from differing beliefs, values, philosophies and professional socialization processes.<sup>18</sup> The two models also hold different views about the relationship between the care provider and the woman, the use of interventions and the goals and objectives of care.<sup>19</sup> Midwifery care is grounded in the philosophy that pregnancy and birth are normal, physiological processes, while the medical model of birth is based on the prevention of morbidity and mortality through the detection of risk.<sup>19</sup>

These two models are not necessarily mutually exclusive and it would be simplistic to expect that all health professionals strictly subscribe to the philosophical tenants of their respective model. However, it became evident from the interviews that these two models of care converge within the context of interprofessional interactions and influence the experiences of midwifery clients.

There were examples from the interviews which illustrated a theme of cooptation where the desires and choices of women are overruled in favour of biomedicine and hierarchy. The interviews with midwifery clients suggest that women are aware of a hierarchy of physician-centred care during the everyday experience of interprofessional consultation. A few of the women interviewed, although they were aware of the hierarchy, dismissed it as insignificant in shaping their experience. They normalized the presence of the hierarchy and accepted it as being a consequence of the scope of practice of midwives. For example, when the midwifery scope of practice prevented the midwife from providing a required treatment or procedure without an order from a physician, clients seemed to accept the hierarchy because they saw the need for the physician. This situation suggests that when the power of the physician-centred hierarchy is reproduced around physicians' prescribing orders, midwives and midwifery clients have little opportunity to choose alternatives. However, the argument that a hierarchy is necessary due to the limited scope of practice of the midwife is problematic because it does not examine the reasons why the midwife's scope is limited.

The medical model emphasizes that physicians, as the keepers of biomedical knowledge, should be awarded authority and power. This position of cultural authority based on possessing a specific body of knowledge, has supported a hierarchical health care system. This hierarchy, which places the physician as superior to other health professionals, and superior to clients and patients, was evident in all of the participants' interviews. The hierarchy of roles in the everyday process of consultation showed that the physician-centred model has a very profound effect on the experience of women. This supports Lorber's<sup>20</sup> contention that although supplemental care by other health professionals may offer a client-friendly service, it does not alter the medical hierarchy.

The physician-centred hierarchy appears to be sustained through a defined scope of practice for the midwife and at least partly justified through what could be called 'personality' arguments. Yet, an argument that hierarchy is due to certain individual

personalities may ignore how situations of patriarchal dominance arise. To date, much of the literature on interprofessional practice has also focused on similar 'personality' arguments by examining characteristics or traits which either strengthen or impede interactions between different health professionals. Characteristics such as willingness to work with others, respect, trust, and communication are often cited as the crux of successful interprofessional teams.<sup>9</sup> This simple list of desirable traits gives the impression that these abilities can be cultivated by individuals by following a recipe or a set of instructions. What is missing in this description of characteristics is a more critical look at the systemic power relations that contribute to their formation.

An individualized explanation for interprofessional relations ignores the role that power and professional socialization play in the interactions between different professionals and between the physician and patient. As a result, there will continue to be exoneration for those who do not respect the professional jurisdiction of others because "it is just their personality."

Physicians trained in a medical school that reinforces the authoritative knowledge of biomedicine and the physician-centred model learn quickly that they carry significant power and control within the health care system and the way they interact with others may reflect these strongly held beliefs.<sup>20</sup> The authority yielded through the physician-centred model becomes a source of power imbalance.<sup>21</sup> This power imbalance creates a clearly-defined hierarchy with the client at the bottom and the midwife as a relatively powerless, 'semi-professional' confined to the middle ground.

These power imbalances which affect the everyday experience of Ontario midwifery clients are the same influences which have prevented the successful regulation and funding of midwifery in Alberta and until recently, legislation in some

Atlantic Provinces.<sup>22</sup> However, in the midst of these stories, there were also stories of how midwives, consultants and women are enacting a woman-centred model of care that challenges the patriarchal system that historically excluded women and their knowledge from participating in decision making.

When reflecting on regulation and integration, Bourgeault<sup>22</sup> feared that Ontario midwives would experience a limited scope of practice and increased subordination, bureaucratization and medicalization. The midwifery client interviews have revealed examples where this is apparent, however, there is also evidence that midwives and women continue to fight against these influences.

Women's experiences of the interprofessional consultation process are complex, with instances of subjugation and resistance occurring simultaneously. All of the women interviewed experienced elements of both models of care during the process of consultation. Enacting a woman-centred model of care during the process of midwifery consultation may require organization of a number of elements such as a favourable hospital environment, a desire by the woman to participate in this model, and a consultant who shares similar philosophical beliefs. When midwives and their clients participate in the physician-centred model of practice, perhaps one of these influences may be preventing the activation of a woman-centred model? As argued by MacDonald, this ideological issue influences how midwives and the women they serve define the new midwifery in Ontario. Ideology informs the care that midwives provide, the production of knowledge, and the engendered identities of midwives and clients.<sup>23</sup>

*...an improved understanding of interprofessional practice would strengthen the foundation for relevant education and training for health professionals.*

## CONCLUSION

The integration of midwives into the health care system, made evident in interprofessional relations, warrants consideration as it provides context for the interconnections between authority, appropriation and autonomy. Accordingly, this research provides

commentary on interprofessional relations between midwives and other health professionals that may be useful in the years to come as midwives continue to find their place in Ontario's provision of maternity care services.

A deeper understanding of the complexity of the interprofessional consultation process is important. This could facilitate improved interprofessional practice through policy, funding and administrative changes within the health care system. Equally important, an improved understanding of interprofessional practice would strengthen the foundation for relevant education and training for health professionals.

From the perspective of the client, this research falls short in the analysis of how issues such as race and class may influence the consultation process. Further research exploring these issues and the opinions and perspectives of midwives and physicians regarding the process of consultation would provide a deeper understanding of the complexity of interprofessional practice.

Divergent professional goals and philosophies, as illustrated by the dichotomy between the physician-centred versus woman-centred birth, may be a significant barrier to interprofessional maternity practice.<sup>24</sup> Interprofessional practice grounded on a patient-centred approach may minimize the possible power imbalances. It is essential that more research be done to explore the views of clients in the process of interprofessional practice. However, as midwives and women attempt to maintain a woman-centred model of care, they are drawing a road map for the future directions of interprofessional practice.

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## AUTHOR BIOGRAPHY

**Beth Murray Davis** is a registered midwife from Hamilton, Ontario, Canada. She is currently on a leave of absence from active practice with the Community Midwives of Hamilton while pursuing doctoral studies at the University of Sheffield in England. While abroad Beth holds a post as a Senior Lecturer in Midwifery at Sheffield Hallam University.

### Address correspondence to:

Beth Murray Davis, RM, MA  
120 Beddoe Drive, Unit 18  
Hamilton, Ontario, L8P 4Z4  
Email: [bmurray@mcmaster.ca](mailto:bmurray@mcmaster.ca)