

Maternity Nurses and Midwives in a British Columbia Rural Community: Evolving Relationships

Sages-femmes et Infirmières du département de Maternité dans une communauté rurale de la Colombie-Britannique : Relations en constante évolution

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ABSTRACT

The purpose of this study was to examine the dynamics and evolution of inter-professional relationships between registered midwives and nurses in a rural community where midwifery has become well established over twelve years. Interviews explored the responses of maternity nurses, a nurse manager, and a public health nurse to the integration of midwives in a rural hospital in south east British Columbia. Factors which helped to bring resolution to early concerns were discussed, along with evolving understandings of roles and responsibilities. Participants reflected on the impact of midwifery on job satisfaction and on the character of the maternity unit. Initial concerns following integration included competence and liability, the history of unregistered midwifery in the community, and the loss of job satisfaction for nurses who had a diminished role in the care of labouring women. Nursing shortages and workload issues created some appreciation of the extra help provided by midwives, but also caused some inter-professional tensions. Although close and functional professional relationships developed, significant grey areas remain in the definition of shared roles and responsibilities with midwives.

KEYWORDS

midwives, rural, interprofessional, nursing

This article has been peer-reviewed.

RÉSUMÉ

Le but de cette étude était d'examiner la dynamique et l'évolution des relations interprofessionnelles entre les sages-femmes enregistrées et les infirmières dans une communauté rurale où la pratique sage-femme s'est établie avec succès depuis douze ans. Les entrevues tenaient compte des réactions des infirmières de l'unité de maternité, de l'infirmière en chef et de l'infirmière du département de Santé Publique face à l'intégration des sages-femmes dans un hôpital rural du sud-est de la Colombie-Britannique. Les facteurs qui aidèrent à résoudre les préoccupations de première heure furent discutés avec en parallèle, la compréhension progressive de la définition des rôles et des responsabilités. Les participantes réfléchirent à l'impact de la pratique sage-femme sur la nature du département de maternité et sur le taux de satisfaction au travail. Les préoccupations sur la compétence et la responsabilité surgirent immédiatement après l'intégration, comme le cas de sages-femmes non enregistrées dans la communauté, la perte d'une certaine satisfaction au travail de la part des infirmières qui eurent à accepter un rôle

de moindre importance quant au soin et à l'accouchement des femmes. Par ailleurs, l'aide supplémentaire apportée par la présence des sages-femmes allégea les problèmes de manque de personnel infirmier mais causèrent aussi quelques tensions interprofessionnelles. Même si certaines relations étroites de travail fonctionnèrent très bien au niveau professionnel, il y eut quand même des zones grises significatives quant à la définition du partage des rôles et des responsabilités avec les sages-femmes.

MOTS CLÉS

sages-femmes, rural, interprofessionnel, profession infirmière.

Cet article a été évalué par des pairs.

INTRODUCTION

As newcomers to the maternity care delivery system in British Columbia, registered midwives have faced challenges in developing positive inter-professional relationships within hospitals. One major deterrent to rural midwifery practice has been the perception that rural physicians and nurses with no prior exposure to the midwifery model of care may be reluctant to accept midwives as colleagues.¹ In B C, while it is possible for a midwife to call in a midwife colleague to assist at a hospital delivery, the model calls for nurses to act as second attendants. Relationships with nurses are crucial to a safe and comfortable work environment, as well as to midwives' ability to provide positive experiences for clients in hospital.²

The benefits to women who are cared for by collaborative teams of health professionals, in this case by registered midwives (RMs) and registered nurses (RNs), includes enhanced care and increased safety due to the different skills and perspectives of the professionals involved.^{3,4} Health professionals can benefit from learning each other's approaches and from an appreciation of each other's strengths.³ At the same time, the potential for conflict rather than co-operation is present due to different values, training, and communication styles among maternity care providers.^{4,5,6} Add to these barriers competition for control and territory, and the lack of familiarity of rural care providers with the midwifery model of care and the prospects for multi-disciplinary teams can appear bleak.^{5,6,7}

Midwives in British Columbia are independent primary health care providers, working in a model which emphasizes continuity of care.² For maternity nurses, a labour involving a midwife is very different

from one involving a family doctor. Physicians may be present at times during the labour, are available for the birth of the baby and placenta, but leave much of the care during and after the labour to the maternity nurse. With a midwife-led labour, the role of the nurse is significantly reduced because the midwife assumes many of the tasks the nurse would normally perform when working with a physician. In B.C., the nurse may assist the midwife during first stage of labour and she plays an important support role during the second and third stages of labour.² Although the midwife takes the lead in management of care, nursing and midwifery roles overlap in many areas and are not always clearly or specifically defined by policy.

The tensions between midwives and nurses were apparent following the passage of legislation regulating midwifery in B C in 1998. The roles and responsibilities of each profession were not well understood.⁸ Rather than caring for patients collaboratively, midwives and nurses were observed to function at a level of "parallel practice"; each profession working separately at designated tasks, with a low level of shared communication or common philosophy of care.⁹ While working relationships between midwives and nurses have evolved in somewhat different ways from one community to another, rural midwives comparing notes at a symposium hosted in Vancouver by the Center for Rural Health Research, in the spring of 2009, agreed that winning support and acceptance from nurses is still a major hurdle for many rural midwives.¹

PURPOSE OF STUDY

The research described in this paper examined the evolution of professional relationships between

midwives and maternity nurses in a small hospital in the south-eastern interior of B.C. It forms a portion of a larger case study investigating inter-professional relationships in this rural community where midwifery has become well established over a twelve year period. Specific objectives of this study were to:

- Identify the initial and ongoing challenges to effective working relationships between nurses and midwives in a rural B.C. community.
- Understand nurses' perceptions of how issues were resolved and the factors which brought about positive change.
- Evaluate the impact on nurses of including midwives on the maternity care team from the perspectives of work environment, job satisfaction, and workload.
- Contribute to the understanding of maternity care delivery systems which includes midwives and provide information concerning inter-professional relationships which might support the introduction of midwifery into areas of B.C. not yet served by midwives.

METHODOLOGY

In this qualitative study, semi-structured focus group interviews were held with maternity nurses. As the researcher and research assistant work as midwives in the community, the advantages and challenges inherent in this "insider" perspective were carefully considered. Interviews were conducted by an outside facilitator, and observed and documented by an assistant. The facilitators were provided with a set of questions to guide conversation within the focus groups. These were general and open-ended, leaving nurses free to suggest and pursue topics which were important to them. Nurses were asked to comment on their preconceptions and initial feelings about the integration of midwives in the hospital. They were asked what they considered to be the challenges in adapting to this new situation, the factors which were most helpful in resolving difficulties, and the extent to which some issues remained unresolved. They also discussed their perceptions of midwifery care in relation to their own standards, impact on the

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unit as a whole, and their views of patient satisfaction with this model of care. The community-based researcher and assistant independently analysed and developed codes for the data. These were later reviewed and a final coding system determined by consensus. A third researcher, from the Center for Rural Health Research, offered input to all phases of the project.^{10,11,12,13}

The bias of the researcher plays a part in the outcome of any study. In this case, it was necessary to walk a fine line between the roles of team member and observer/researcher. An attempt was made to make the best use of the subjectivity inherent in the situation, while enhancing objectivity as much as possible.¹⁴ The author's intimate knowledge of the community and the work environment was a positive factor. Making use of the verbal and written observations of the facilitator and the interview note taker in interpreting the material added an outside perspective. The nurses themselves were engaged as much as possible in the research process. Nursing input was solicited in creating the trigger questions used in the interviews, and the results and recommendations of the research were brought back to the nurses for comment at one of their staff meetings.

Ethics approval was obtained from the Behavioural Research Ethics Committee at the University of British Columbia as well as from the Interior Health Research Ethics Committee.

Research Setting

Kootenay Lake Hospital in Nelson provides service to the municipal area with a population of 10,000 as well as a number of neighbouring communities, bringing the population served to over 25,000 people.¹⁵ The number of births in this hospital has been climbing in recent years, approaching 330 births in 2008-09.¹⁶

RESULTS

Ten out of 14 potential subjects participated from the staff of maternity nurses, as well a Nurse Manager

and a Public Health Nurse were also participants.

Confusion about Roles and Concerns about Competence

As midwives began to work on the maternity unit, nurses felt confused about the role they were expected to play during a midwife-managed delivery.

What was going to be my role? What was theirs? And where do I back off and where do I take charge? - RN.

Nurses were unsure about the midwife's scope of practice as well as their training and skills. The care provided was different from what the nurses were accustomed to when working with doctors. Nurses recognized that some midwifery patients had expectations which were unusual compared to those of many of their other maternity patients. Midwives brought women into hospital that might previously have given birth at home. Sometimes the expectations of midwives and their patients challenged the nurse's sense of safety in the situation.

I think nurses want to have a little bit more of a controlled environment whereas the midwives are a little bit more laid back and more into what the woman wants. That was one of the big issues I think when it first started. It was "this is how it should be, this is how we've always done it". And the midwives are more into patient satisfaction, maybe. Not that the nurses aren't into that too ... the philosophy of maybe the nurses wanting a little more control and midwives wanting the patient to feel they are in control a little more. Sometimes that's to their detriment, sometimes we need to move fast. We've got a baby in trouble... we can't be sitting here for the next 20 minutes or half an hour to see whether the woman is going to consent to a section or not. We need to move, we need to go now. And sometimes that is an issue. The midwives want to talk it through and let the patients talk it through, let them make their decision. And sometimes we're losing time.

Home Birth History

Prior to the registration of midwives, some nurses had experience caring for women who had been transferred into the hospital from home deliveries attended by lay midwives. Some of these were emergency situations or situations in which the

parents were deeply suspicious of the medical system and refused recommended care. It was apparent that some were difficult and frightening experiences for hospital staff. Nurses who had not had personal experiences had heard the stories. All shared concerns that the perceived dangerous practices which had been going on outside of the hospital might now be brought into the hospital by the midwives. "It was a horror show sometimes, just a horror show..." Another nurse acknowledged that she might have had a limited perspective on home birth in the community.

We were coming from the history... of just hearing the stories in the community, and you only heard the bad stories, you don't even know if they are true stories. You just heard stories.

One nurse indicated that she welcomed the advent of registered midwifery hoping that it would bring increased safety to women who might otherwise have looked outside the system and chosen an unattended home birth.

Threat to Job Satisfaction

Nurses in rural hospitals are not able to choose a specialty and work in it exclusively.^{7,17,18} Instead, they are required to move from one area of the hospital to another as needed. Many of the nurses indicated that they enjoyed working on the maternity unit, felt they had developed expertise in that area, and loved the relationships with labouring women and new mothers. Some would have preferred to work maternity exclusively. When nurses learned that midwives would be caring for patients throughout the first stage of labour they feared losing the aspect of their job which had given them the most satisfaction in the past. One nurse stated: "...it was a huge threat in the beginning because they were going to do what we do." Another stated:

I loved being a part of the coaching, that's when I'm at my best to be with my moms... and giving that up was really hard. I went through a grieving process of letting that go, and I did, and then I embraced the midwives.

For some nurses, grief led to anger, resentment, complaints, and reluctance to help out.

I think there was a lot of anger for some people because they came on the floor, so it was like the midwives have to do everything themselves. And the simplest things... the midwife didn't wash the basin out right...or she didn't dump the linen. The nurses were finding a place to focus.

In describing their work, nurses spoke of their role as caretakers of hospital policies. Although accustomed to carrying out orders written by physicians, they felt "in charge" on their own unit most of the time. Patients looked to them for reassurance, care, and support. Nurses spoke about how seriously they take these responsibilities. Although all nurses acknowledged that the midwives welcomed their presence and involvement in the labour room, the nurses initially felt that the woman's strong relationship with the midwife would make their presence redundant, or even intrusive. On the other hand, when they did not spend time with the patient, they were aware of being out of touch with the labour and uncertain about whether they were fulfilling their responsibilities in relation to the patient.

I understand that the midwives and the clients have a relationship that they usually established through a long antenatal, you know they really work with them. So I just see myself as standing back and being there for support... versus the patients that come in that maybe have a family physician.

It's going to interfere on our turf. We're used to having control over our labour and deliveries. Our moms would come in and we were in charge...we did everything for them...

I have difficulty not knowing what's going on down that hallway and policy and procedure of this hospital state that we are responsible for whatever's going on.

Changing Relationships

Policies

Although a policy statement relating to midwives was available on the unit, none of the nurses interviewed was familiar with the contents or indicated that the policy had helped to improve collaborative relationships with midwives. The policy contained information on the scope of practice as defined by the College of Midwives of B.C. as well as general

information on midwives' and nurses' roles during labour. Included was an algorithm for a conflict resolution process if needed.¹⁹ From the perspective of the nursing administrator, policies were crucial in integrating midwives. However, from the point of view of improving day to day interactions with midwives, policies and meetings were not the key factors nurses identified. One nurse stated, "I don't know if I ever read it (midwifery policy)."

Time and Trust

I think more than anything, time, and a commitment on the part of the midwives (made the difference). I tell you they were committed because it was a somewhat hostile environment they were coming into.

Nurses stressed that the process of accepting midwives took a long time, measured in years rather than weeks or months. Relationships were built on the experience of observing effective patient care and good outcomes, one case at a time and one nurse at a time.

...it was a slow building of trust, it's almost like building a level of trust with your co-worker. You don't know what their skill level is, you don't really know what their commitment is, you don't know how conscientious they are, and it's just over the years that you realize that when somebody says I'm going to do this, I'm going to do that... I'll watch her. It's just a matter of trial and error, just how you develop trust with a co-worker, with a friend.

Nurses placed a high value on the needs and preferences of patients. As they observed midwifery patients over time, they saw benefits to the close antenatal relationship midwives formed with patients, the one on one care in labour, and the postpartum support.

The patients were happy and...I had to realize it wasn't about me anymore, it was about - What does the patient want? What do they want in the community? And the patients loved it, and it just spread like wildfire.

Increasing trust worked in both directions. Nurses found midwives became gradually more open and communicative and more willing to share their

patients.

We share more a little bit. I think as the trust has come, they relinquish a bit to us more, which never happened years ago. Now if it's the night time and they're tired, maybe they've had a birth during the day, you know, I can say to them 'why don't you go lay down for a while, I can stay here'. And they will. Whereas they wouldn't before and it's nice because I get time to bond with the patient too.

As they became familiar with the midwives' approach, nurses were more willing to strategize to find ways to solve problems. Many developed a rhythm of spending time in the labour room at intervals during the first stage of labour. Some potential conflicts were defused through creative thinking, as in the following situation where some midwifery patients preferred to delay the baby's admission bath.

One of the instances that I remember that was recent, was the midwives don't, or their patients don't want their babies bathed yet. And of course, then it's a body fluid contact situation that the nurses don't want to touch the baby until they've been bathed because of what has been taught. So we eventually found a system. If the baby's not been bathed, there's a little yellow teddy bear that gets stuck on the door, and so the nurses know when they see the little yellow teddy bear that that baby's not been bathed and they need to go and put gloves on to change the baby and so on because they've not had their initial bath. So that was a way that they problem solved that one, rather than going to the midwives and saying 'you have to do this. This is the way it is in the hospital. You have to do it.

In a small community, people meet in a variety of roles, inside and outside the hospital, at social events, on the ski hill, at high school graduation ceremonies. For rural nurses, the personal and the professional are closely intertwined.¹⁷ Personal relationships both inside and outside the hospital were significant in improving professional relationships. "And they're friends now too. We see them at different parties, we see them downtown, I ski with C..."

Ongoing Challenges

Roles: Grey Areas

For most participants, increased comfort in sharing the care of patients with midwives developed over the years. At the same time, many cited grey areas around roles and responsibilities which continue to cause problems. There were a variety of opinions about which issues were most troublesome, as well as different views on the midwife's status as primary caregiver and the nurse's liability. Some were certain that the nurse's legal responsibility for the patient was the same with a midwife as with a doctor. Others said they felt less responsible because they were less involved but were uneasy about whether the midwives adhered to the same standards as nurses.

I just assume that it's the same as the physician. So she ultimately makes those calls and she is responsible for making those calls.

I somehow feel less responsible because we are less involved... But the midwifery practice - they don't necessarily do the same things that we do, so therefore I let them do it the way they're going to do it. But that's not the way I would do it...

Situations where the midwife's scope of practice required consultation with a physician were especially difficult. Hospital policy calls for one to one nursing care for augmentations of labour, for example.^{19, 2} A physician, in consultation with the midwife, orders the augmentation. The midwife usually remains with the patient, managing most aspects of the labour. Nurses interpreted their roles in this complex scenario in individual ways, but were uncertain about what they should actually be doing. (Note: Recent changes to the midwifery regulation will give midwives the ability to manage augmentations of labour).

We know what we're supposed to do when there's a doctor. We know exactly what we're supposed to do.

Rural midwives across the province have complained that they receive less nursing support for housekeeping tasks such as clean up after delivery and transfer of mother and baby to the postpartum unit than do their urban counterparts.¹ Help with these chores was dependent on the individual nurse's preference in this setting.

Some nurses will just say 'well, that's not my job'.

And that's not clearly defined. Who cleans the instruments or who cleans the mess in the room?"

Nurses pointed out that the roles are often interwoven and overlapping, impossible to define absolutely. "Yes. And we couldn't do that. To say this is my area and this is your area. But that didn't work so well."

Communication and Charting

Nurses agreed that communication with midwives has improved over the years. They also felt that they wanted even more communication, such as updates about the progress of labours and critical information about patients' social and emotional histories. One nurse complained that occasionally a midwife contradicted advice a nurse had given in the presence of the patient undermining her own status with that patient. The Public Health Nurse did not see midwives taking enough advantage of possibilities to collaborate in caring for postpartum women. "We'd love to be on their radar," she said, echoing the views of some maternity nurses who wished that they were more "part of the midwife's team."

Charting was considered an important mode of communication by the nurses. Many felt that the midwives did not chart meticulously enough. The language midwives used in their written assessments was not always the language the nurses would have used.

The report I get from the midwives is a lot vaguer than the report I get from an RN. So I communicate more easily with an RN because we're trained the same way.

On the other hand, nurses acknowledged that, while all practitioners chart their own actions and assessments, the nurses fill out the numerous summary forms for physicians and organize the chart. Some nurses help midwives with this; some do not. "Do they chart as a nurse or as a doctor?" asked one nurse. Charting was an area where differences of style and expectations between the professions were very apparent in the discussions.

...when it's a doctor delivery, it's basically our chart and we take care of it. When it's with the midwives, we're sharing this chart, and sometimes I don't know

how to share. And I keep thinking it's your patient and you should be charting the way I chart, but you're not. Or sometimes you're not. Right, so we're sharing a chart, it's like sharing a journal, it's weird and it gets messy sometimes.

Impact of Nursing Workload

"We're getting spread thinner all the time." National studies highlight an impending human resource crisis in health care which will most likely include a significant nursing shortage. Canada's population of nurses is aging and a sufficient number of new graduates to fill the gaps have not been produced. By 2011, a shortage of 78,000 nurses is predicted, rising to a shortage of 113,000 nurses within five years.^{3,20}

Rural areas where retirement rates are expected to be high and recruitment and retention are more difficult, will likely be most severely affected.^{21,22}

Nurses at this hospital discussed the reality of too much work and too few hands to do the work. This is a situation which is unlikely to improve and is very likely to become more severe for nurses. Midwives providing care for women means less work for nurses.

It relieves me in terms of my workload, when I know a patient is coming in with a midwife. Oooh relief! Another body on the floor.

When a physician manages the labour, the nurse is obliged to attend to the patient, even when aware of other needs on the unit. The midwife's presence allows her to spend her time elsewhere. If other demands are very pressing, she may not be available to the midwife and her patient when her assistance is needed. Some nurses acknowledged that under the pressure of too many demands on their time, a nurse may choose to interpret her role with a midwife's patient in a minimalist fashion. The midwife may not receive safe or reasonable support.

I know that more work comes on to us following a doctor delivery and we kind of expect the midwives to carry more and that's where I'm not sure what is the correct way.

DISCUSSION

"I think it is really true that the mutual appreciation has just

grow, and grown, and grown", stated one nurse. "I worry a lot more with women going home without midwives."

Rural nursing is characterized by the importance of personal relationships in inter-professional dynamics and nurses' strong commitment to the welfare of their communities.^{17,21,23} These are factors which have played a major role in the evolution of positive collaborative relationships between nurses and midwives in this community. Rural nurses have strong connections with their communities, and know many co-workers and patients on a personal basis. Their initial fears about deficiencies in midwifery practice and competence were based on their concern for patient welfare. As they began to see benefits for women, attitudes towards midwives began to shift. Certainly, forming personal relationships, both in the unit and in the community, was a crucial aspect of improving professional relationships.

Barriers to effective teamwork include differences in education and communication styles, as well as differences in values and philosophy.^{18, 20, 21, 22, 23, 24, 25}

These factors have significantly impacted relationships between nurses and midwives in this community. Nurses were frustrated when midwives did not utilize the communication tools of the unit as expected, or when they used language which was different or unfamiliar. They found midwives' approaches to informed choice to be unnecessarily involved. They worried that patient safety might be impacted by the time taken by these discussions, or by the compromises made to accommodate women's choices. It would be facile to conclude that nurses have a lesser commitment to informed choice than midwives. They clearly demonstrate interest in patient teaching and sensitivity to patient diversity. They appear to have boundaries which are different from those of the midwives with respect to perceptions of safety and the importance of hospital policies and procedure. These may be rooted in their training, as well as in the nature of nurses' roles within the hospital, where they are responsible for maintaining the routine and functioning of the unit. Issues of control and turf protection also stem from

"I worry a lot more with women going home without midwives."

these defined roles. Considerable time and effort are required to engender confidence in the new midwife's competence. Perception of the competence of other professionals, shared professional goals, and personal trust have been postulated to be the foundation for collaboration.²⁵

Grey areas remain around shared roles and responsibilities. Nurses agreed that clear definitions of responsibility in areas such as charting and immediate postpartum care of mother and baby would be helpful. Some nurses were willing to offer to take over the care of a patient for a period of time to allow the midwife to get some rest during a long labour. Other nurses might not respond in the same way. Although the need for consistency is obvious, it is simplistic to assume that all role-related issues in the complex relationship between nurses and midwives can be resolved by policy.

Opportunities for ongoing evaluation and discussion involving midwives, nurses, and nurse managers are needed to work out some of these issues. The influence of workload pressure on nursing support for midwives and their patients is important and has the potential to impact quality of care for patients, in addition to its impact on professional relationships. National studies propose collaborative teams including midwives, physicians and nurses to provide a solution to human

resource shortages in communities where local maternity care is at risk.^{3,20} Excellent working relationships between professions would be a prerequisite for such arrangements. Acceptance by other health care providers is essential for midwives to provide their services into other rural areas of British Columbia. Understanding the dynamics involved when maternity nurses and midwives together care for women and babies in hospitals is an important step toward creating satisfying, collaborative, professional relationships and providing optimal care for patients.

Reflections on the Process

When nurses were given the opportunity to have preliminary talks with the facilitator before the interviews began, some expressed concern that their

comments might negatively affect their relationship with the midwives. "There are things we have never said to them (the midwives)", explained one of the nurses. In fact, the process stimulated open conversations. Midwives and nurses met at a nursing staff meeting to listen to the interview findings. In this context, midwives were able to speak of their need for breaks in long labours, as well as the importance of nursing support in the immediate postpartum period. Later, at a potluck lunch including midwives and maternity nurses, a document clarifying roles and responsibilities was jointly presented by a nurse and a midwife, followed by more discussion. Rather than negatively affecting relationships, the research became a part of the evolving process towards more collaborative relationships between nurses and midwives.

RECOMMENDATIONS

Policies

1. Organize meetings between midwives applying for privileges and maternity nurses and nursing administrators. Review scope of practice, consultation, home birth practices, and communication from home births, roles and responsibilities. This will provide a basis for shared care of the patient. Provide a context of regularly scheduled meetings to address questions as they arise.
2. Locate a document defining roles and responsibilities of nurses and midwives in an accessible, logical location on the unit.
3. Define roles and responsibilities with attention to areas where roles must be precisely defined as well as to areas where functions overlap and flexibility is required.
4. Evaluate protocols which define the personnel needed for safe care during the second stage of labour, and the immediate postpartum period. Ensure participation of the R.N. as indicated.
5. Clarify the roles of midwives and nurses in managing patient charts.
6. Ensuring adequate communication between midwife and R.N. around the progress of labour.
7. Incorporate provision of rest breaks and relief for midwives.

Inter-Professional Education

1. Provide inter-professional NRP training for RMs

and RMs.

2. Provide inter-professional training in emergency skills on a regular basis with a program such as MORE-OB, or through a hospital based emergency skills program.

Midwifery Strategies for Clear, Collaborative Relationships with Nurses

1. Discuss the nurse's role with clients during prenatal care.
2. Include the nurse in the admission of the patient when possible, allowing the nurse to be introduced to the family and brought up to date on patient history.
3. Update the nurse on the progress of labour, management strategies, and any concerns, on a regular basis through the course of the labour.
4. Request information about workload and discuss strategies.
5. Take advantage of opportunities for professional discussion and social interaction.

Limitations

Every rural community is unique as is every rural maternity care service. A wide range of circumstances including, geography, degree of isolation, availability of specialist back up and other factors can shape the character of inter-professional relationships in a given community. In smaller settings, the influence of one or two individuals can set the tone for professional interactions. The details of the evolution of relationships between nurses and midwives are site specific and cannot be generalized beyond the study participants. However, some of the insights gained in this community may have application in other settings.

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