

Exploring collaboration between midwives and nurses in Nova Scotia:

A feminist poststructuralist case study

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## Abstract

**Background:** In 2009, midwifery became a regulated profession and was integrated into the delivery of perinatal health care in Nova Scotia at three model sites. The integration process was challenging for health care providers, and particularly for midwives and nurses, who have different scopes of practice, yet similar roles and skills. Little is known about how midwives and nurses collaborate.

**Purpose:** The purpose of this study was to explore collaboration between midwives and nurses in Nova Scotia, Canada.

**Methodology:** This research was conducted as an instrumental case study, guided by Stake's approach for qualitative case study research. Intersectional feminist poststructuralism (IFPS) provided the theoretical perspective to explore concepts of power, discourse, and gender, as they related to collaboration between midwives and nurses. Individual, one on one interviews with 17 participants were audio-recorded and transcribed verbatim. Twenty-five documents were reviewed, and field notes were maintained. Feminist discourse analysis was used to analyze the data.

**Findings:** Four main themes were identified; 1) Negotiating Roles and Practices: 'Every Nurse is Different, Every Midwife is Different, Every Birth is Different', 2) Sustaining relationships: 'The more we can just build relationships with one another', 3) Reconciling Systemic Tensions: The Medical Model and the Midwifery Model, 4) Moving forward: A Modern Model for Nurses and Midwives Working Together.

**Discussion and Implications:** This study illustrated the potential for building more collaborative teams of midwives and nurses in Nova Scotia, and in Canada. Midwives and nurses in Nova Scotia are positioned to demonstrate leadership in a midwife and nurse led birthing model of care that works. More research, leadership, government funding and support is needed to implement this model of care.

**Conclusion:** The findings of this study can be used to build sustainable, collaborative, equitably distributed midwifery (and birthing) services in Nova Scotia, and throughout Canada.

## **Dedication**

For Charlene MacLellan,  
with love and gratitude  
to you for introducing me to the  
values, beliefs, and practices of midwifery.

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## **Glossary of Terms**

**Collaboration** – Active, respectful contributions of teams members in order to achieve a shared goal.

**Direct-entry Midwife** -A person who has received midwifery education at the Baccalaureate level, who has not received additional nursing education.

**Discourse** – A group of common assumptions that are often invisible because they contribute to knowledge that we take for granted.

**Family-centered care** - Acknowledges that all aspects of a person and their family are important for their participation and decision-making during a person's health care.

**Feminist poststructuralism** – A philosophical perspective and a methodology that combines feminist and poststructuralist theories. A researcher who uses feminist poststructuralism recognizes that realities are constructed and change depending on time, context, experience, and power. A feminist poststructuralist is interested in exploring how discourses are socially, historically, and institutionally created and maintained, and how gender, power, and language are used to position discourses marginally or hegemonically.

**Gender** - A social construction based on traditional understandings of biological sex.

**Intersectionality** – An approach to understand the interactions of subject positions such as gender, race, class, etc., and how those interactions can marginalize or privilege individuals, practices, and ideologies in different ways.

**Language** - How knowledge and the meanings of experiences are expressed. With multiple languages and meanings in existence, a singular universal meaning is difficult to assign to an aspect of language.

**Nurse-Midwife** - A person who has received nursing education and who has received additional specialized midwifery education.

**Patient-centred care** – Health care that is inclusive and responsive to a patient's needs, values and preferences.

**Perinatal care** – Health care provided to a birthing person during pregnancy, including birth, and into the postpartum period following the birth.

**Person-centred care** – An inclusive and respectful approach to the development and sustainment of healthful relationships all care providers, service users and others significant to the lives of persons receiving health care.

**Power relations** - A changing dynamic process between persons that exists everywhere which depends on action and becomes visible through its use.

**Registered Nurse** - A person who has received nursing education and who maintains a nursing license to practice with a nursing licensing body.

**Registered Midwife** -A person who has received midwifery education and who maintains a midwifery license to practice with a midwifery licensing body.

**RN Second Attendant** - A Registered Nurse who is a second attendant at home births where midwives are the primary health care provider.

**Woman-centred care** - Women are centered as primary decision-makers and active participants in their health care.

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### **List of Abbreviations**

|        |                                                             |
|--------|-------------------------------------------------------------|
| CAM    | Canadian Association of Midwives                            |
| CAPWHN | Canadian Association of Perinatal and Women's Health Nurses |
| CNA    | Canadian Nurses Association                                 |
| FPS    | Feminist poststructuralism                                  |
| ICM    | International Confederation of Midwives                     |
| MCNS   | Midwifery Coalition of Nova Scotia                          |
| NS     | Nova Scotia                                                 |
| NSHA   | Nova Scotia Health Authority                                |
| RM     | Registered Midwife                                          |
| RN     | Registered Nurse                                            |
| SA     | Second Attendant at Home Births                             |
| SOGC   | Society of Obstetricians and Gynaecologists of Canada       |
| WHO    | World Health Organization                                   |

## **Chapter 1: Introduction**

### **1.1 Background**

Improving and strengthening existing access and capacity for midwifery and nursing services have been identified as priorities by the World Health Organization (2016). Currently, midwives and nurses comprise 50% of the health workforce in many countries throughout the world (World Health Organization, 2016). Despite the large number of midwives and nurses who contribute to the global health workforce, midwifery and nursing services are not equitably distributed (World Health Organization, 2016a). With a continuing overall shortage of human health resources globally (World Health Organization, 2016a), in-depth understandings of how midwifery and perinatal nursing care is provided within local contexts is urgently required in order to ensure the equitable access to quality maternal-newborn health services for all women.

Compared to other maternity care models, midwife-led continuity models of care have been found to have better outcomes for birth (Sandall, Soltani, Gates, Shennan, & Devane, 2016). Reported improved outcomes have included; reduction in the use of epidural analgesia, episiotomies, and instrumental births, fewer pre-term births, an increase in spontaneous vaginal birth, increased maternal satisfaction, and a trend for cost-effectiveness in the delivery of maternity care (Sandall et al., 2016). Based on these findings, Sandall et al. (2016) recommended that midwife-led continuity of care should be available to all women with low-risk pregnancies. Despite the important contributions that midwives make to maternity care, midwifery services are not universally accessible or equitably distributed in many countries (United Nations Population Fund, 2014).

## **Canada.**

During the 1980's, while Canada did have unregulated midwifery, it was the only country in the global north that did not formally include regulated midwifery in maternal-newborn health care services (Bourgeault, 2000). For Canada, the benefit of being so late to incorporate midwifery into maternal-newborn health care was the opportunity to study different models of midwifery in various countries around the world. For example, prior to the regulation of midwifery in Ontario, the first Canadian province to regulate and offer midwifery services, decision makers, policy creators, and interested stakeholders examined how midwifery had been incorporated in birthing care in other countries, specifically The Netherlands (MacDonald & Bourgeault, 2009; Rooks, 1997c), and also the United Kingdom (Rooks, 1997c) and the United States (MacDonald & Bourgeault, 2009; Rooks, 1997c). Despite the argument from nursing and medicine that midwifery should require prior nursing education and training (Bourgeault, 2000), midwifery was regulated as an autonomous health care profession in Ontario in 1991, with the legislation taking effect in 1993 (College of Midwives of Ontario, 2018a; Plummer, 2000; Rooks, 1997c).

From a global perspective, the regulation of midwifery as a profession that is autonomous and distinct from nursing is unique to Canada. For example, there are long histories of nurse-midwifery in the United Kingdom, the United States, and Australia (Bourgeault, 2006; Rooks, 1997c) where midwives are nurses who have undertaken specialized training in nursing. Unlike the Canadian model, midwifery is understood to be an extension of nursing work in these countries and therefore in order to become a midwife, one must first train as a nurse. This is different from countries such as The Netherlands and New Zealand, where midwives are autonomous primary maternity care providers who provide the majority of birthing care services

to women with low-risk pregnancies (DeVries, Wiegers, Smulders, & vanTeijlingen, 2009; Hendry, Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Rooks, 1997c). In these two countries, midwives are distinct from nurses, and nursing training is not a pre-requisite for midwifery licensure. Further, in The Netherlands and in New Zealand, perinatal care is distinctly the responsibility of midwives with little or no mention of the involvement of nurses (DeVries et al., 2009; Hendry et al., 2009).

In Canada, depending on the province in which midwifery services are offered, midwives and nurses may work together to provide prenatal, intrapartum and/or postpartum care to women and newborns. For example, the provinces of British Columbia and Nova Scotia have second attendant policies identifying registered nurses, among other health care providers, as approved second attendants at home births, provided they are qualified and meet specific criteria (College of Midwives of British Columbia, 2018; Midwifery Regulatory Council of Nova Scotia, 2017a). Midwives may also work with nurses in hospitals, during labour, delivery, and the postpartum period. The practice arrangements for midwives and nurses can also extend into the community with community or public health nurses working together with midwives prenatally or in the postpartum period. There are many opportunities for collaboration between midwives and nurses during the perinatal care of women and newborns. The collaboration between Canadian midwives and nurses is unique to the model of midwifery which has been integrated into Canadian maternal-newborn health care.

The Canadian model of midwifery has several core values that guide the overall models of care in Canadian provinces. These include: a belief in pregnancy and childbirth as normal physiological processes, the right of women to make informed decisions regarding all aspects of care, the development of relationships with women to maintain continuity of care with their

primary maternity health care provider, full responsibility to provide autonomous birthing care within their scope of practice, a commitment to provide evidence-based maternal-newborn care, and women's rights to make informed decisions about the location birth – home, birth centre, hospital (Canadian Midwifery Regulators Council, 2018b). These values have shaped and defined midwifery across Canada and they have supported the growth of a singular identity of midwifery. These values have also informed expectations of practice for Canadian midwives. It has been important for midwives to have a clear identity given the variations in provincial legislation, geography, resources, and cultural contexts in which midwives work across the country.

Midwifery is provincially regulated in Canada (Canadian Midwifery Regulators Council, 2018b). Since its regulation in the province of Ontario, midwifery has been regulated in all the Canadian provinces and territories with the exception of the Yukon and Prince Edward Island (Canadian Association of Midwives, 2018b). The provincial government for Prince Edward Island has also recently announced their commitment to regulate and integrate midwifery into maternal-newborn health care (Ross, 2016). Midwifery has been regulated in New Brunswick and recently integrated at pilot site for midwifery (Canadian Association of Midwives, 2018b).

Due to the provincial regulation of midwifery in Canada, provincial regulatory bodies for midwifery are responsible for the licensing of Registered Midwives, commonly abbreviated as RM (Canadian Midwifery Regulators Council, 2018b). Midwives provide care to women during low-risk pregnancies, throughout labour and childbirth, and throughout the six weeks following birth (Canadian Midwifery Regulators Council, 2018b). In the event that complications arise, midwives consult with obstetricians, paediatricians, and physicians as appropriate (Canadian Midwifery Regulators Council, 2018b). In Canada, midwives provide primary birthing care in

hospitals, homes, and birthing centres (Canadian Midwifery Regulators Council, 2018b).

Canadian midwives complete a four year baccalaureate degree (Canadian Association of Midwives, 2018a) followed by a certification exam for licensure (Canadian Midwifery Regulators Council, 2018c).

Canadian midwifery has grown from 500 midwives practicing in 2005 to over 1300 practicing in 2015 across the country (Canadian Association of Midwives, 2015a). Yet despite the increase in the number of practicing midwives, midwifery services are still not equitably available to women and their families in Canada. For example, midwives in several provinces report a demand for their services that exceeds the capacity and resources they have to provide midwifery services (Association of Ontario Midwives, 2015; CBC News, 2015; Lowe, 2014). In the province of Nova Scotia, midwifery services were integrated into maternal-newborn health care at three model sites when midwifery was regulated in 2009 (Midwifery Regulatory Council of Nova Scotia, 2016). Midwifery services have not yet been expanded beyond these three sites despite recommendations from an external assessment team, to integrate midwifery services into at least one more site in the province (Kaufman, Robinson, Buhler, & Hazlit, 2011). The foresight to identify registered nurses amongst other health care professionals as potential second attendants for home births illustrates both a willingness for midwives to collaborate with other health care providers and recognition of potential capacity challenges during the initial integration of midwifery services. With improved capacity, through collaboration between midwives and nurses, there was an increased likelihood that an equitable distribution of midwifery services can be realized provincially and throughout Canada.

## **Nova Scotia.**

Midwifery was regulated as a health care profession in the province of Nova Scotia in 2009 (Midwifery Regulatory Council of Nova Scotia, 2016), more than twenty years after midwifery was first regulated in a Canadian province. This makes midwives the newest members to join health care teams at the three model sites where midwifery services have been integrated into maternal-newborn health care. During hospital births, midwives and nurses both maintain a continuous presence with women and families throughout labour, delivery, and the early postpartum. The continual presence of both midwives and nurses throughout these stages of childbirth is unique. For example, prior to the regulation of midwifery in Nova Scotia, nurses were the providers of continuous labour, delivery, and postpartum care for hospital births. Physicians and obstetricians arrived for deliveries, but nurses were physically present and provided continual care throughout labour, delivery and the postpartum period. With the inclusion of midwives in maternal-newborn health care teams in Nova Scotia, this dynamic has changed. When a midwife is the primary care provider, it is both the midwife and nurse that are present throughout labour, birth and early postpartum period. This means that midwives and nurses are also in the continuous presence of one another as they support women and families throughout these stages of childbirth.

Registered nurses have also attended home births with midwives, in the role of second attendants in Nova Scotia. During home births, second attendant registered nurses assist with the second and third stages of labour (Midwifery Regulatory Council of Nova Scotia, 2017a). Interestingly, despite their continuous proximity to each other during hospital and home births, little is known about collaboration between midwives and nurses (Macdonald, 2015; Macdonald

et al., 2015). Thus the proposed research seeks to explore collaboration between midwives and nurses.

### **1.3 Research question and issues**

In this study, I sought to address the question; how do midwives and nurses collaborate in the provision of childbirth care for women in Nova Scotia? Specifically, I was interested in exploring the relations of power between and amongst the two provider groups. I was also interested in how historical, social, and institutional discourses influence their experiences of collaboration. To effectively examine these dimensions of collaboration between the two provider groups, I conducted a feminist poststructuralist case study. This question is congruent with case study informed by feminist poststructuralism and intersectionality.

According to Stake (1995), case study requires the identification of issues, informed by the research question. The overall research question for this feminist poststructuralist case study is: how do midwives and nurses collaborate in Nova Scotia? Based on this research question, I have developed six issues that will be used to guide my proposed case study. These research issues are similar to specific research objectives (or specific research sub-questions) in other research traditions. Issues identified for this study are:

- a) What is the meaning of collaboration, during the provision of perinatal care, for midwives and nurses?
- b) How do midwives collaborate with nurses during the provision of perinatal health care?
- c) How do nurses collaborate with midwives during the provision of perinatal health care?
- d) What are service users' (mothers) perspectives of collaboration between midwives and nurses during perinatal health care?

- e) What are administrative stakeholders' (managers, decision makers, etc.) and health care provider colleagues' (physicians, obstetricians, doulas) perspectives of collaboration between midwives and nurses?
- f) How do social, historical, and institutional discourses influence collaboration between midwives and nurses in Nova Scotia?

A comprehensive understanding of the collaboration experiences of midwives and nurses in Nova Scotia has the potential to strengthen policy and practice for collaborative birthing care.

#### **1.4 Significance of study**

This study has significance for nursing because of the important role that nurses have in collaborative maternity care because of their flexibility and adaptation to changing perinatal needs (Medves & Davies, 2005). It is also important because of the close proximity in which midwives and nurses are now working and because of similarities between midwifery and perinatal nursing skills and roles (Benoit, 1991; Epp, 2010; Macdonald, 2015; Macdonald et al., 2015; Plummer, 2000; Relyea, 1992; Young, 2010). Recognizing there are barriers, structural and otherwise, to collaborative maternity care in Canada and that representatives from midwifery and nursing indicate interest in and support for collaboration (Peterson, Medves, Davies, & Graham, 2007), the findings of this study have the potential to enhance existing collaborative relationships between midwives and nurses. The findings of this study also have the potential to inform clinicians, decision makers, and policy creators for capacity building and an expansion of midwifery services and midwife-led models of care in Nova Scotia, and Canada.

This study responds to priorities for midwifery research in Canada that were developed by multidisciplinary researchers in 2001 (Kornelsen, 2001). The researchers identified the need to explore how midwifery and nursing co-exist and interact, and the need to explore the

historical, political and social integration of midwifery into Canadian maternity care as research priorities (2001). These areas of research have relevance for Nova Scotia, where midwifery regulation is relatively recent and where midwifery integration is not yet complete.

This study is also significant because it will address a clear gap in the literature about collaboration between midwives and nurses (Macdonald, 2015; Macdonald et al., 2015). In a systematic review of qualitative evidence, one of the main findings indicated that negative experiences of collaboration between midwives and nurses may be caused by issues of disrespect, unprofessionalism or inconsideration, and unclear roles (Macdonald, 2015; Macdonald et al., 2015). Although only five studies were synthesized for this systematic review, it illuminated challenges experienced by midwives and nurses during collaboration with one another (Macdonald, 2015; Macdonald et al., 2015). To address this gap in the literature, the authors suggested that future areas for research should include explorations of the power dynamics of collaboration between midwives and nurses using qualitative methods, such as feminist poststructuralism (Macdonald, 2015; Macdonald et al., 2015).

The identified gap in the literature about collaboration between midwives and nurses is interesting and may be reflective of the uniqueness of the midwifery model in Canada, which has integrated midwifery alongside perinatal nursing. Each profession has maintained separate professional identities. Despite this unique model of care, these professions share similar roles and skills and need to negotiate those similar roles and skills when they collaborate with one another (Macdonald, 2015; Macdonald et al., 2015). In addition, there is still a lot of misunderstanding about midwifery. Through multiple conversations with my nursing colleagues, I realized that some nurses do not know a lot about midwifery as a regulated profession. They are not aware of the evidence that supports midwifery-led care (Renfrew et al., 2014; Sandall et al.,

2016; Thiessen, Nickel, et al., 2016) and the safety of home birth (Hutton et al., 2016), or the philosophy of midwifery (Gaskin, 1990). This study provides an opportunity to explore how dominant discourses have shaped understandings of midwifery and how these understandings have influenced collaboration between midwives and nurses. The data and insights generated from this research can assist in the development of innovative approaches to the delivery of equitable midwifery-led and nursing supported approaches to birthing care in Canada.

### **1.5 Situating self**

I have been interested in midwifery since I was a teenager, when I was paired with a local midwife for a high school co-operative education placement. This was many years prior to the regulation of midwifery in Nova Scotia. At that time, midwifery was alegal in Nova Scotia which meant that midwives offered perinatal care and attended home births without formal recognition or endorsement from the provincial government. Practicing midwifery was not illegal, it simply didn't have legal status. This experience introduced me to the philosophy of midwifery. I learned to trust the process of birth and to believe in women's capacity to give birth which had a profound effect on my beliefs and understandings of birthing and women's health. This socialization into midwifery philosophy and the midwifery approach to birthing care informed my strength-based attitude and approach to birth and birthing.

I have supported the women in my life throughout their birthing and parenting journeys as a knowledgeable lay person, doula, and encouraging friend, using a strength-based perspective that was focused on the abilities of women and their bodies which was influenced by my early socialization in midwifery. I eventually decided to become a Registered Nurse, with the intention of working in perinatal care. While providing postpartum care to women and families, I came to recognize that my philosophy of care was not always congruent with the time and space

currently allotted by the health system for me to provide the care that I believe women and families deserve. This led me to consider how midwives and nurses could create a space for birthing care that is informed by a midwifery philosophy of care.

Since the late 1990's, I have kept current with midwifery politics and midwifery progress in Nova Scotia and throughout Canada. I began to hear anecdotally, and through media reports, that the initial integration of midwives at one of the sites in Nova Scotia was very challenging (Kaufman et al., 2011; Taylor, 2012) after midwifery was regulated there in 2009. Several years later, I worked in a regional hospital that was not one of the model sites, but which had a strong history of unregulated midwifery care prior to regulation. I spoke with nursing colleagues at that site, about midwifery and uncovered their distrust and wariness about the skills and roles of midwives. They questioned the place of midwifery within the health care system, believing that their nursing role and skills were being duplicated by midwives who attended hospital births. Collectively, these conversations have cemented my commitment to understand more about how midwives and nurses are collaborating in Nova Scotia. I hope that this research will serve as a touchstone to enhance and support existing and future birthing care collaborations in Nova Scotia and Canada.

Engaging in research to explore collaboration between midwives and nurses in Nova Scotia is important to me for several reasons. First, I believe in the need to provide equitable access to midwifery services for all women in Nova Scotia and Canada and I believe that maternity care providers must engage in creative collaborative partnerships. The findings from this study have the potential to inform strategies for future collaborative endeavours. Secondly, I feel a responsibility as a registered nurse and midwifery advocate to help bridge the gap in knowledge and understanding about Canadian midwifery. Thirdly, this is an opportunity for me

to demonstrate nursing leadership in maternal-newborn health. We need more nurse leaders in maternal-newborn health research and practice who actively contribute to improving collaboration. I hope to inspire other nurses working in maternal-newborn care to seek research and/or leadership opportunities.

### 1.6 Definition of key concepts

The definitions of several key concepts are required to ensure that our understandings of these terms remain consistent throughout the study. The key concepts that will be defined include; midwife, nurse, collaboration, power, and gender. Key concepts as they relate to my philosophical perspectives and the methodology will be provided in each of those sections.

According to the Nova Scotia Midwives Regulatory Council (Midwifery Regulatory Council of Nova Scotia, 2005), **midwives** are defined using the International Confederation of Midwives definition of a midwife. The definition is as follows;

A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the *ICM Essential Competencies for Basic Midwifery Practice* and the framework of the *ICM Global Standards for Midwifery Education*; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.

(International Confederation of Midwives, 2017)

In Nova Scotia, and the rest of Canada, the legal title of a midwife is Registered Midwife, while the use of the term ‘midwife’ is often used in less official capacities (Canadian Midwifery Regulators Council, 2018b).

In Nova Scotia, there are two types of **nurses**, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Registered Nurses are nurses who are prepared at the baccalaureate level and who have completed a certification exam (College of Registered Nurses of Nova Scotia, 2018). Licensed Practical Nurses are prepared at the diploma level and also complete a certification exam in order to practice (College of Licensed Practical Nurses of Nova Scotia, 2015). Registered nurses have been identified as qualified for second attendant positions at home birth according to the second attendant policy (Midwifery Regulatory Council of Nova Scotia, 2017a), they are also the second attendant during labour and delivery in hospital births. For those reasons, the registered nurse definition will be used for this study. The Canadian Nurses Association defines Registered Nurses as;

RNs are self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities and populations to achieve their optimal levels of health. At all stages of life, in situations of health, illness, injury and disability, RNs deliver direct health-care services, coordinate care and support clients in managing their own health. RNs contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research and policy (Canadian Nurses Association, 2015).

The concept of **collaboration** has many different definitions. For the purpose of this study, the definition created by the National Primary Maternity Care Committee during the Multidisciplinary Collaborative Primary Maternity Care Project (2006) will be used. This definition has unified endorsement from the three Canadian associations that represent midwives and nurses (Canadian Nurses Association, Canadian Association of Midwives, Canadian Association of Perinatal and Women's Health Nurses). Following is the definition,

Collaborative woman-centered practice designed to promote the active participation of each discipline in providing quality care. It enhances goals and values for women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines. (Society of Obstetricians and Gynaecologists, 2006, p. 15)

Foucault talked about the concept of **power** in terms of power relations, where power is not static, but an ever changing dynamic process between persons that exists everywhere (Foucault, 1982; Weedon, 1987). He also stated that the exercise of power is the way that certain actions modify the actions of others (Foucault, 1982). He argued that power is productive in how it allows for the creation of certain knowledge and for certain knowledge to be known (Cheek, 2000; Foucault, 1982).

**Gender** is described as a social construction based on traditional understandings of biological sex (Butler, 2007). The performative aspect of gender means that gender identity is fluid and not a stable entity (Butler, 2007). For Weedon (1987), gender is socially constructed and varies depending on the discourse in which it is situated.

In this chapter I have provided a short introduction to this research, including the research purpose, research question, and the significance of the study. I have added transparency to my position as an individual, researcher, nurse, and midwifery ally through the section in which I situated myself. Finally, I have provided definitions for relevant concepts to the conduct of this research. In the next chapter, I will provide a more in-depth literature regarding midwifery and nursing globally, in Canada, and in Nova Scotia.

## **Chapter 2: Literature Review**

In this chapter, I will describe the literature reviewed for this study. These include peer-review journal articles, textbooks, academic books, grey literature, and hand-searching of journal articles and relevant websites. The search strategy was complex in order to capture the varied contextual factors of midwifery and nursing in Canada and in other countries. Search terms to identify relevant materials included; midwi\*, nurs\*, collaborat\*, histor\*, various country and province names, midwifery and nursing regulatory bodies.

The findings from the literature review are organized under the following topics; global midwifery, history of midwifery in Canada, regulation and integration of midwifery in Canada, midwifery education in Canada, perinatal care in Nova Scotia, nursing and perinatal care in Nova Scotia, Canadian midwives and nurses, beliefs and values about birth, and collaboration. To begin I will contextualize midwifery globally, followed by a brief history of midwifery in Canada, as it relates to the geographic, cultural, and indigenous contexts. Next, I will discuss the regulation and integration of midwifery in Canada. I will provide an overview of the context of perinatal care in the province of Nova Scotia. In the following sections, I will discuss nursing in Canada, the similarities between Canadian midwives and nurses, beliefs and values about birth, collaboration, and identified research needs for Canadian midwifery.

### **2.1 Global Midwifery**

There are an estimated 20.7 million midwives and nurses working in health care around the world (World Health Organization, 2016a). As the predicted shortage of midwives and nurses becomes a reality, it will become increasingly important to strengthen the capacity of both professions in numerous ways, including the creation and sustainment of collaborative partnerships in order to meet the health needs of our global population (World Health

Organization, 2018). The World Health Organization (WHO) has recognized the important contributions that midwives and nurses make to health care, “Acting both as individuals and as members and coordinators of interprofessional teams, nurses and midwives bring people-centered care closer to the communities where they are needed most, thereby helping improve health outcomes and the overall cost-effectiveness of services,” (2016, p.6). There are numerous models of birthing care that depend on the contributions and expertise of midwives and nurses, as described previously by the WHO, for their sustainability and delivery of quality health care to women and newborns. As such, a better understanding of midwifery globally will help to contextualize Canadian midwifery and perinatal care.

### **2.1.1 Models of birthing care.**

In the book titled *Birth Models that Work*, the authors provided a list of characteristics they argued are present when models of birthing care work (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). The list of characteristics was determined by the authors of the book based on their understandings, experiences, and research of a variety of birthing models of care. The book itself provides exemplar models of birthing care that work in a variety of contexts and locations throughout the world.

Of the twenty-three listed characteristics (See Appendix A), two have specific relevance for this study. The first one is the need for respectful and collaborative relationships amongst all providers of health care (Davis-Floyd et al., 2009). For this study, I was interested in developing a deeper understanding of collaboration between midwives and nurses in Nova Scotia. A deeper understanding of collaboration between these two provider groups will support decision making and the development of strategies aimed at improving birthing care in Nova Scotia. The findings

also have the potential to support the development of innovative approaches to birthing care in the province and throughout Canada.

The second characteristic, identified by the authors of *Birth Models that Work*, that is relevant to this study, is sustainability (2009, p. 23). The sustainability of midwifery services in Canada is becoming more important as the demand for midwifery increases. Sustainable midwifery services are also important given the noted decline of birthing care providers in Canada (Biringer, Maxted, & Graves, 2009; Chan & Willett, 2004; Kaczorowski & Levitt, 2000; Klein, Kelly, Spence, Kaczorowski, & Grzybowski, 2002). An adequate number of sustainable midwifery practices across Canada will ensure that women with low-risk pregnancies receive appropriate care for their needs. In order to ensure there are an adequate number of sustainable midwifery-led models of care, innovative and collaborative partnerships will be required. Understanding how collaboration is currently being experienced between midwives and nurses in Nova Scotia may provide insights to help us strengthen and enhance existing collaborative partnerships, and this understanding may also inspire innovative approaches to collaborative birthing models led by midwives and supported by nurses.

### **2.1.2 Types of midwives.**

Midwives have a variety of names, credentials, and education around the world, despite the unifying definition of a midwife provided by the International Confederation of Midwives (International Confederation of Midwives, 2017). Two common terms for midwives are nurse-midwives and direct-entry midwives. Nurse-midwives receive a nursing education first and then this is followed by midwifery education or training, usually at the post-graduate level. For nurse-midwives, midwifery is viewed as an advanced practice role for nurses. Direct-entry midwives, often referred to as midwives, do not require nursing education. Direct-entry midwives can enter

a midwifery program, usually a degree or diploma program, directly after completion of their secondary education. Direct-entry midwives view midwifery as an autonomous profession, separate from nursing.

#### ***2.1.2.1 Nurse-midwifery.***

Three places where nurse-midwives can be found to be a part of the birthing care system include; the United Kingdom, Australia, and the United States. In this section I will present a brief historical perspective of nurse-midwifery education, registration, and regulation in these three countries as a comparison to Canadian midwifery. It is important to understand nurse-midwifery and midwifery globally due to the similarities and differences of education, registration and regulation between countries. I have chosen these three countries because nurse-midwives have been well-integrated into their health care systems and as such have influenced the evolution of Canadian midwifery in different ways.

In the United Kingdom, midwifery has played an integral role in the continued evolution of the maternal-newborn healthcare system. Professional midwifery in the United Kingdom is the result of a decision to include midwifery in maternity care (Cross, 2014). Midwifery has also changed over the years, with transitions of identity and scope of practice.

In 1890, the Standards for the Queen's Nurses were issued and Queen's Nurses practicing in rural areas were expected to have midwifery training, although they were not permitted to perform midwifery duties except in the case of an emergency (Howse, 2006). It was essentially the use of nurses, with precautionary midwifery training, by poor rural families that established midwifery as an important part of district nursing (Howse, 2006). In 1897, the Conditions of Affiliation for Country Nursing Associations was issued and provided sanction for village nurse-midwives to practice in villages (Howse, 2006). The village nurse-midwives were not hospital

trained and their midwifery training was provided to them in return for completion of a 3 year work contract within their county (Howse, 2006).

In 1902, the Midwives Act was passed in England (I. Bourgeault, 2006; Cross, 2014; Howse, 2006). This act regulated midwifery and granted medical authority to midwives, such that they had professional status to work in partnership with physicians (Cross, 2014). Yet, despite being the first health profession to be regulated in Britain after physicians, midwives were not responsible for managing their own regulatory processes (Bourgeault, 2006). Due to the 1902 Midwives Act, a midwifery examination was introduced by the Central Midwives Board after 3 months of midwifery training (Howse, 2006). By 1924, the duration of midwifery training was increased to 12 months for women with no nursing training, and to 6 months for women who had received training as Queen's Nurses (Howse, 2006). Village nurse-midwives were not exempt from the midwifery examination despite their lack of literacy skills which were required for them to understand and pass the exam (Howse, 2006). The passing of the Midwives Act in 1902 created the first identifiable professional division in midwifery in Britain with three kinds of midwives; a) certified midwives who were trained at a recognized institution, b) certified midwives who had practiced midwifery for at least one year prior the passing of the Midwives Act and who were of good character, and c) handywomen who were untrained and unregulated, and often preferred by women living in working-class communities due to financial affordability (Cross, 2014). Handywomen were permitted to practice midwifery until the Midwives Act was revised in 1936 (Cross, 2014).

In the 1930s there were two models of care that were available for childbearing women. One provided hospital based services, while the other provided community-based maternity services (Benoit et al., 2005). In 1936, the Midwives Act was revised adding nursing training as

a requirement for licensure, this essentially eliminated non-nurse midwives from practice (Bourgeault, 2006). During the 1960s and 1970s, midwifery started to be regarded as a specialty in nursing (Bourgeault, 2006). Although home birth was most common during the 1960s (Department of Health, 2010), by 1970 the government recommended that births should take place in hospital (Benoit et al., 2005). Midwives continued to be the primary maternity care provider, however their role became fragmented due to the increasing use of technology and limits in their scope of practice (Benoit et al., 2005).

Currently, all four countries in the United Kingdom recognize the value and importance of autonomous midwifery, with midwives positioned in a central role in birthing care (McInnes & McIntosh, 2012). Currently, healthy women are offered a choice of birthplace; home, hospital, or midwifery unit (Sandall, 2013). Women choosing birth in an obstetric unit will have their care provided by a team of maternity care professionals, homebirths and births in midwifery units are attended by midwives (Redshaw, 2011).

The Nursing and Midwifery Council is clear that midwifery is distinct from nursing (The Nursing and Midwifery Council, 2018b). Despite this assertion, there are two educational pathways to midwifery, one for nurses who can undertake an 18 month midwifery course and then apply for dual registration with both nursing and midwifery regulatory bodies (The Nursing and Midwifery Council, 2018a). The other option is to enter a 3 year program at an educational institution approved by The Nursing and Midwifery Council (The Nursing and Midwifery Council, 2018a). Undergraduate programs are comprised of at least 40% theory and at least 50% practice (McInnes & McIntosh, 2012).

With an increase in births and consistent understaffing of midwives, England has faced a chronic shortage of midwives in recent years (McInnes & McIntosh, 2012). Maternity support

workers have been introduced to assist with the workload practicing midwives are currently facing (McInnes & McIntosh, 2012). Although maternity support workers provide care under the supervision of midwives, uncertainty remains about their role within clinical academic and teaching spaces (McInnes & McIntosh, 2012)

In Australia, midwifery has experienced many transitions and changes over the years. In 1824, settlements that were isolated on the coast of Australia had ‘accidental midwives’ who attended the births of the women in those areas (Barclay, 2008). These were untrained women who assisted women throughout childbearing as a matter of necessity. By 1862, the Medical Registration Act was passed (Grehan, 2004; Hastie, 2006). This act ensured that unqualified medical practitioners, including midwives, did not provide medical care to the public (Hastie, 2006). This legislation also made it necessary for midwives to receive midwifery training, supervised by physicians (Hastie, 2006), and after the completion of nursing training (Barclay, 2008).

Midwives were the pre-dominant providers of birthing care in Australia (Barclay, 2008; Fahy, 2007), despite the arrival of Nightingale nurses, from England in 1871 (Barclay, 2008), who were trained to maintain a subservient role to physicians due to Nightingale’s integration of a militaristic approach to nursing (Fahy, 2007). By 1892, the Nurses Association of Australia was established (Grehan, 2004) and this was followed by the requirement of a more formalized 12 month midwifery training course which was mandatory for all women providing midwifery services who did not have training as a nurse (Barclay, 2008). For women who had prior nursing training, the midwifery training could be shortened to 6 months (Barclay, 2008). In 1907, four hospitals began to provide hospital-based midwifery training where midwives undertaking their

training in a hospital enjoyed the associated prestige of being a 'hospital midwife' (Barclay, 2008).

In 1915, the Midwives Registration Bill was passed which allowed both vocationally trained midwives and nurses with formal midwifery training to register (Fahy, 2007). Neither medicine nor nursing agreed to train vocationally prepared midwives, which Fahy (2007) suggests is evidence for the joint plot of both professional bodies to eliminate midwives completely. In 1916, a recommendation from a government inquiry was issued that only trained nurses or midwives, supervised by a physician, should provide birthing care during labour and delivery (Fahy, 2007). This resulted in the end of the independent midwifery, which had been accepted up until that time. Interestingly, in 1923, the Nurses Act was introduced which excluded nurses from providing any type of birthing care without having registration as a midwife in addition to their nursing registration (Fahy, 2007). By 1926, all states in Australia had the means to register midwives (Bogossian, 1998).

In 1928, another Nurses Act passed which gave nursing regulatory control over midwives (Fahy, 2007). During this time nurse-midwifery care was provided to women in rural and remote locations due to the shortage of physicians in those regions (Fahy, 2007). This is the point where midwifery was effectively encompassed by nursing, with midwives needing nursing and midwifery training (Hastie, 2006).

In 1982, a report that approximately 5000 babies were being born at home in Australia over the previous 5 or 6 years led to a movement that put pressure on the government to support home birth (Barclay, 2008). The movement was successful, and home birth was sanctioned by the government (Barclay, 2008). In 1992, midwives were unable to practice without the supervision of a physician (Bogossian, 1998).

Between 1984 and 1993, midwifery training moved from hospitals into tertiary level educational institutions (Hammond, Gray, Smith, Fenwick, & Homer, 2011). By 2002, direct entry programs were introduced in two states (Hammond et al., 2011) and the first graduates from these direct entry programs entered the workforce in 2005 (Hastie, 2006). By 2010, there were 11 direct-entry midwifery programs operating throughout the country (Hammond et al., 2011). Currently, the most common educational route for people who want to become a midwife is through a 12 month long post-graduate qualification following nursing training (Hammond et al., 2011). The second route is through a 3 year direct-entry Bachelor of Midwifery program.

In terms of the regulation of midwifery in Australia, the regulatory standards have not changed significantly since 1915 (Gray, Rowe, & Barnes., 2016). The regulation and registration standards were set by each state and territory individually, which means that as a country, Australia does not have national midwifery regulatory body (Gray et al., 2016). This independent approach to regulatory and registration standards has impeded mobility for midwives wanting to work in other states (Gray et al., 2016). In fact, in some areas in Australia, non-nurse midwives were registered as nurses with restrictions limiting them to the practice of midwifery only (Gray et al., 2016). This changed in 2010, when Australia introduced the Australian Health Practitioner Regulatory Agency for all health care providers in the country (Gray et al., 2016). Until the creation of this regulatory authority for all health care providers, regulatory bodies in Australia had difficulty distinguishing between vocationally or direct-entry prepared midwives and nurses with midwifery qualifications (Homer et al., 2009).

There are many models of maternity care in Australia (Gray et al., 2016; Homer et al., 2009). The subject of the separation of midwifery from nursing has been the cause of ongoing debate (Homer et al., 2009) with a prominent assumption that a midwife becomes a nurse first

(Bogossian, 1998). Given my previous discussion of a general history of midwifery and its regulation in Australia, this is understandable, particularly as regulation and registration for midwives and nurses has been so intertwined.

In Australia, midwives can be nurses with additional training or they can be registered midwives without a nursing background (Fahy, 2007). Midwives can work in private or public hospitals and they can attend home births (Wilkes, Gamble, Adam, & Creedy, 2015). Approximately one third of birthing women access private care, with the majority of birthing women using public maternity care (Stevens, Thompson, Kruske, Watson, & Miller, 2014). It is rare to be able to access public or privately funded home birth services (Wilkes et al., 2015). Community midwives practicing privately face challenges maintaining continuity of care because of the difficulties they have acquiring hospital visiting privileges, with midwives having these rights in only one state (Wilkes et al., 2015). In order for midwives to be covered by publically funded medicare, they must subscribe to a list of criteria, yet this limits their practice to only the hospital setting as there is currently no medicare available for home birth (Wilkes et al., 2015).

In addition to the previously mentioned challenges of midwifery practice, is the fact that since 2001, indemnity insurance has not be available for midwives attending home births in most of Australia (Catling-Paull, Foureur, & Homer, 2012). There are 12 publically funded home birth programs available in the whole of Australia with indemnity insurance provided to midwives in some parts of Western Australia (Catling-Paull et al., 2012). Although the home birth rate is currently less than 1% (Stevens et al., 2014), the obstacles for midwives to be able to provide home birth services to those who want home births are many. For those willing to use the private system, private midwifery care with planned home birth is simply not supported (Stevens et al.,

2014). Generally speaking, midwives in Australia face a number of barriers which prevent them from working to their full scope of practice (Homer et al., 2009).

The roots of nurse-midwifery in the United States can be traced to the 1920s (Reale, 2002) when maternal and neonatal mortality rates were high (Dawley, 2002, 2003; Rooks, 1997d; Schminkey & Keeling, 2015). In 1921, Mary Breckinridge returned to the United States from France (Dawley, 2003) where she had been introduced to British nurse-midwives during an assignment with the Red Cross (Rooks, 1997d). Between 1921 and 1923, Breckinridge prepared to introduce this British style of nurse-midwifery to the United States (Dawley, 2003). As part of this preparation, Breckinridge published a community assessment of the care that granny midwives were providing to pregnant and birthing women which identified deficiencies in knowledge about how to respond to or prevent obstetric emergencies (Schminkey & Keeling, 2015). In 1925, after Breckinridge had received certification as a nurse-midwife from the Central Midwives Board in England (Dawley, 2003), she founded the Frontier Nursing Service in Kentucky (Dawley, 2002, 2003; Rooks, 1997d; Schminkey & Keeling, 2015). The Frontier Nursing Service was privately funded (Dawley, 2003; Schminkey & Keeling, 2015) and it established 8 nursing centers within its first 10 years (Schminkey & Keeling, 2015).

Breckinridge was forward-thinking in recognizing the need to understand how nurse-midwifery impacted maternal and neonatal birth outcomes. She enlisted a statistician to assist in keeping records of vital statistics for the area that the Frontier Nursing Services served (Dawley, 2003; Rooks, 1997d). These statistics were collected and maintained for 35 years (Dawley, 2002) and illustrated the marked decrease in maternal and neonatal mortality due to the introduction of nurse-midwifery care (Rooks, 1997d). In addition to maintaining records of the outcomes of births that nurse-midwives attended in Kentucky, Breckinridge also ensured that nurse-midwives

were legally protected in the provision of maternity care. Breckinridge created 'Medical Routines' in collaboration with a physician, which effectively acted as standing orders from a physician in the delivery of perinatal care (Rooks, 1997d; Schminkey & Keeling, 2015). In using this approach, nurse-midwives were considered to be working under the supervision of physicians, while at the same time maintaining their professional autonomy and working within the legal jurisdiction of nursing.

By 1931, the Maternity Center Association in New York City began providing midwifery services and opened the first nurse-midwifery education program (Dawley, 2002, 2003; Rooks, 1997d). Breckinridge sent one of the British trained nurse midwives from the Frontier Nursing Service to assist with the nurse-midwifery education program (Dawley, 2003; Rooks, 1997d). By the end of the 1930s the Frontier Nursing Service had opened its own educational program for nurse-midwives (Dawley, 2002; Rooks, 1997d). These two nurse-midwifery programs remained the only programs to educate nurse-midwives until the 1940s (Dawley, 2002). In 1941, a third nurse-midwifery program opened in Alabama which graduated 33 African-American nurse-midwives over its 5 years of existence (Dawley, 2002). The women who entered the program in Alabama had prior public nursing training (Rooks, 1997d). In 1944, the Catholic Maternity Institute opened in New Mexico and offered nurse-midwifery services and education (Dawley, 2002, 2003; Rooks, 1997d).

In 1955, the American College of Nurse-Midwifery was established (Dawley, 2002; Rooks, 1997d). This was after the establishment of the American Association of Nurse-Midwives in 1941 in Kentucky (Bourgeault, 2006). In order for nurse-midwives to work under the legislation of their RN licenses, the American Nurses Association issued a statement indicating the nurse-midwifery was an extension of nursing practice in 1968 (Dawley, 2002). By

1969, the American College of Midwives was established through a merging of the American College of Nurse-Midwifery and the American Association of Nurse-Midwives (Bourgeault, 2006). By the 1970s, nursing leaders were arguing that a Master's degree needed to be a requirement for nurse-midwifery licensure (Dawley, 2002).

The 1960s and 1970s also saw a move toward lay midwifery in the United States, with women opting to attend one another's births instead of going to hospital. One of the most notable proponents of this movement, who in later years became an icon for home birth in the United States was Ina May Gaskin. Her 1975 book, *Spiritual Midwifery* offered women an alternative to hospital births attended by physicians (Rooks, 1997b). *Spiritual Midwifery* provided the stories of Gaskin and her fellow lay midwives who learned about childbirth through their attendance at each other's' births and the births of women who sought their assistance (Gaskin, 1990).

In 1982, the Midwives Alliance of North America was formed to provide non-nurse midwives with professional representation (Midwives Alliance of North America, 2016). This alliance of non-nurse midwives marked the clear division between nurse-midwives and midwives who had chosen different paths to midwifery. As a result of a working group between the Midwives Alliance of North America and the American College of Nurse-Midwives, both organizations agreed that non-nurse midwives could become certified midwives through midwifery programs accredited by either of the two organizations (Dawley, 2002). For nurse-midwives certified through the American College of Nurse-Midwives, they could become a Certified Midwife (CM) and for midwives certified through the Midwives Alliance of North America, they could become a Certified Professional Midwife (CPM) (Dawley, 2002).

Nurse-midwives have been recognized as a primary health care provider at the federal level (American College of Nurse-Midwives, 2016). Nurse-midwives have licensure and

prescriptive privileges in all 50 states (American College of Nurse-Midwives, 2016). In 2010, a master's degree became the requirement for entry to practice as a Certified Nurse-Midwife or as a Certified Midwife (American College of Nurse-Midwives, 2016). A Certified Midwife (CM) is a master's prepared from a general background, whereas a Certified Nurse-Midwife (CNM) is a nurse who is master's prepared (K. Thiessen, personal communication, March 28, 2019). Nurse-midwives attend births in hospitals, birth-centres, and at home with 94.2% of nurse-midwife attended births occurring in hospital in 2014 (American College of Nurse-Midwives, 2016).

#### ***2.1.2.2 Direct-entry midwifery.***

Two countries, excluding Canada, where direct-entry midwives are primary care providers in birthing care are The Netherlands and New Zealand. I will describe Canada's history of midwifery and its current state in the following section. For now, I will describe the historical and present-day contexts of midwifery in The Netherlands and in New Zealand.

The Netherlands is world renowned for a birthing care system that has high rates of home birth (Cronie, Rijnders, & Buitendijk, 2012) and access to comprehensive midwifery services. The Dutch maternity health care system has been built around the distinction between physiological and pathological pregnancy and birth (Amelink-Verburg & Buitendijk, 2010; De Vries, Nieuwenhuijze, & Buitendijk, 2013). This can be traced to 1865 when the Law of Medical Practice was introduced (Amelink-Verburg & Buitendijk, 2010; van der Lee, Driessen, Houwaart, Caccia, & Scheele, 2014). Previous to the enactment of this law, midwives worked independently. The Law of Medical Practice limited midwives to providing care during uncomplicated labours or for natural courses of labour (Amelink-Verburg & Buitendijk, 2010; van der Lee et al, 2014). The law also meant that midwives were not allowed to administer

medications, nor use obstetrical instruments in labour and delivery (Amelink-Verburg & Buitendijk, 2010; van der Lee et al., 2014).

The scope of practice for midwives has expanded numerous times since the initial act and the role and work of midwives was further endorsed within maternity care by the 1941 Ordinance for Midwives (van der Lee et al., 2014). The ordinance ensured that midwifery care was provided to women for free by Dutch insurers (van der Lee et al., 2014). At the heart of the initial act however, was an attempt to make a boundary between physiological births, which could be attended by midwives, and pathological births that required expertise from the medical profession. This boundary continues to inform how maternity care is delivered in The Netherlands, particularly as it relates to determining the risk profile of a pregnant or labouring woman.

In 1958, the Obstetric List of Indications was introduced (De Vries et al., 2013; van der Lee et al., 2014). It was initially created as an insurance directive, but has since become an instrument to guide clinicians in risk assessment (Amelink-Verburg & Buitendijk, 2010). There is now a dichotomous division in the evaluation of risk with a choice between the categories of a high or low risk status (Amelink-Verburg & Buitendijk, 2010; Perdok et al., 2016). Referrals are based on the list of indications (Posthumus et al., 2013) for transfer of care (Perdok et al., 2016).

There are three levels of maternity care in The Netherlands; primary, secondary, and tertiary levels (Amelink-Verburg & Buitendijk, 2010; Posthumus et al., 2013; van der Lee et al., 2014). There are two roles for midwives; primary care midwives and clinical midwives. Primary care midwives provide care to women with low-risk pregnancies, are self-employed and work in the community (Perdok et al., 2016; van der Lee et al., 2014). Primary care midwives transfer care if the risk level changes to high and secondary care is required (Perdok et al., 2016; van der

Lee et al., 2014). Clinical midwives work in the hospital and bridge the gap between primary care midwives and obstetricians (Cronie et al., 2012). Clinical midwives conduct the majority of secondary care births (De Vries et al., 2013) and account for 25% of all midwives in The Netherlands (Cronie et al., 2012). Obstetricians provide in hospital care for high risk pregnancies and labours at both the secondary and tertiary levels. Currently, the Dutch maternity care system is moving toward a more integrated model of care with an emphasis on shared care, where a low-risk woman who developed complications would receive additional care from an obstetrician, this despite findings that women would prefer more individualized care (Baas, Erwich, Wiegers, de Cock, & Hutton, 2015).

Midwifery education for midwives in The Netherlands is not university based (Cronie et al., 2012). Although, there have been suggestions for The Netherlands to upgrade their midwifery education to the university level (Perdok et al., 2016). Instead midwifery education consists of four years of vocational training (Wiegers, Warmelink, Spelten, Klomp, & Hutton, 2014). There is no nationally defined scope of practice for clinical midwives and there is no requirement for additional training to become a clinical midwife (Cronie et al., 2012).

Birthing care in New Zealand is unique for several reasons; the country offers midwife-led care, birthing care is state funded, and midwifery education is direct-entry (midwives do not need prior nursing education) (Skinner & Foureur, 2010). This well supported approach to birthing care has not always been midwife-led or well supported specifically as it relates to midwives and nurses. One author has argued that despite their intertwining histories, the relationship between midwives and nurses has been filled with philosophical disagreements, tensions, and power struggles (O'Connor, 2014).

In 1904, the Midwives Act was passed (Gilkison, Pairman, McAra-Couper, Kensington, & James, 2016; Stojanovic, 2008) which created two classes of midwives in New Zealand (Stojanovic, 2008). One class was for midwives who were formally trained and the other class was for midwives who were untrained (Stojanovic, 2008). In 1925, midwives and nurses were regulated under the same act, the Nurses and Midwives Registration Act (Stojanovic, 2008). This was the first clear nursing initiative to subsume midwifery because this act permitted the registration of maternity nurses and made midwifery training a post graduate course for nurses (Stojanovic, 2008). In 1971, the law redefined midwifery as obstetric nursing and made supervision by an obstetrician a requirement to practice midwifery (Gilkison et al., 2016). By the 1980s, consumers began to lobby for the separation of midwifery and nursing education (Gilkison et al., 2016; Grigg & Tracy, 2013). By 1990, the Nurses Act Amendment was passed which led to the re-establishment of autonomous midwifery and ensured equity between midwives and physicians (Grigg & Tracy, 2013). In 1992, the first direct-entry midwifery education programs began and in 2003, the Midwifery Council of New Zealand was established, ensuring that midwives had their own regulatory body (Gilkison et al., 2016).

Currently in New Zealand, midwives have the option of working in one of two roles. Midwives can be lead maternity carers or core midwives. Ninety-two percent of lead maternity carers are midwives and the rest are composed of obstetricians and general practitioners (Gilkison et al., 2016). Essentially, midwives who work as lead maternity carers work in the community, are self-employed, work flexible hours, and are on call (Grigg & Tracy, 2013). Midwives working as lead maternity carers provide continuity of care and their focus is on primary care (Grigg & Tracy, 2013). Core midwives are employed to work in hospitals and provide care at the secondary and tertiary care levels for women with complex needs (Gilkison et

al., 2016; Grigg & Tracy, 2013). Core midwives can also work with lead maternity carers when women choose to give birth in the hospital (Gilkison et al., 2016). Core midwives work shifts and therefore their continuity of care is more limited than that of a lead maternity carer (Grigg & Tracy, 2013). Midwives are chosen as the lead maternity carer by 75% of women in New Zealand (Skinner & Foureur, 2010).

One of the unique aspects of the midwifery model of care in New Zealand is that midwives provide care to women with mixed risk (Grigg & Tracy, 2013; Skinner & Foureur, 2010). This means that risk does not determine the kind of provider that a woman has. It also means that when a woman's care is transferred from a primary level to a secondary or tertiary level, the midwife is able to continue providing care. This essentially means that the transfer of care from a midwife to an obstetrician actually becomes shared care between the two providers (Skinner & Foureur, 2010). This illustrates the midwifery commitment to continuity of care that has been built into the health system. Midwives provide primary care, secondary care with input from obstetrics, and obstetricians provide tertiary level care (Gilkison et al., 2016; Skinner & Foureur, 2010). Nurses not trained as midwives do not work in maternity care in New Zealand (Skinner & Foureur, 2010).

There are four schools in New Zealand which offer direct-entry midwifery programs (Gilkison et al., 2016). The programs are 3 years in duration and student midwives are taught and assessed by midwife preceptors and the women receiving care (Gilkison et al., 2016). Student midwives must meet the requirement of 4800 program hours, which includes 2400 practice hours, 1920 theory hours, 40 facilitated births, and 100 each of antenatal, postnatal, and newborn assessments (Gilkison et al., 2016). These educational standards have been developed by the Midwifery Council of New Zealand (Gilkison et al., 2016). The three year program is followed

by a mandatory first year of practice mentoring program, designed to assist newly graduated midwives transition from student to practicing midwife (Gilkison et al., 2016).

In this section I provided a global context for midwifery, with specific emphasis on examples of countries that employ nurse-midwives or midwives in their maternity health care systems. These countries were predominantly Western countries with models of midwifery care that were formally integrated into their health care systems prior to the regulation and integration of midwifery services in Canada. As such, the ways in which midwives were historically educated, registered, and regulated in these countries provided insight when integration and regulation decisions about midwifery were being made in Canada. The historical and current background of each of these countries and the intertwining of midwifery and nursing histories are things to consider as we move forward.

## **2.2 History of Midwifery in Canada**

The regulation of midwifery as an autonomous profession in Canada has been fairly recent in the context of the countries discussed previously. Despite being late to regulate and formally include midwifery in Canadian maternity health care, there is actually a long history of unregulated midwifery in Canada (Benoit, 1991; Biggs, 2004; Bourgeault, 2006; Plummer, 2000; Relyea, 1992). There are elements in the Canadian history of midwifery which mirror various aspects of midwifery in other countries. For example, midwives working in rural and remote locations to meet the birthing care needs of women in those regions. There are also differences. Regardless of the similarities and differences between Canada and other countries, it is prudent to develop an historical and contextual understanding of midwifery and nursing within Canada and Nova Scotia, in order to explore and understand current collaborative experiences between these health care providers.

Variations in the histories of midwifery and nursing are reflective of the variations of contexts that have influenced the histories of these two professions. It is important to understand that midwifery and nursing have overlapping and shared histories depending on the geographical and ethno-cultural contexts in which they have been practiced. Following is an historical overview of some specific examples that illustrate the overlapping and shared histories of midwifery and nursing in Canada (Macdonald, 2015; Macdonald et al., 2015; Plummer, 2000).

### **2.2.1 Geographical context of midwifery in Canada.**

Three Canadian provinces offer examples where midwifery and nursing share overlapping histories. While not exhaustive, these examples serve to illustrate how midwives and nurses have shared skills, roles and histories in Canada at different points in time and in different locations. Specific attention will be given to examples from Newfoundland and Labrador, Alberta, and Ontario.

In Newfoundland in 1920, the Midwifery Act established midwifery as a profession (Benoit, 1991; Plummer, 2000). Foreign trained midwives, local women, and nurses trained in maternity care were employed to meet the perinatal needs of women in the remote areas of the province (Benoit, 1991; Plummer, 2000; Relyea, 1992). In 1920, the Midwives' Club initiated a three month course for lay midwives working in remote locations in Newfoundland (Benoit, 1991; Relyea, 1992). From 1924 until 1934, an eighteen month, hospital based program trained 10 maternity nurses per year (Plummer, 2000; Relyea, 1992). The distinction between nurses and midwives was expressed by their titles. 'Maternity nurses' received formal hospital training and 'midwives' completed the three month midwives club course (Relyea, 1992). Midwifery training ended in 1949 and the government stopped licensing midwives in 1961, although the law was left in place (Plummer, 2000). British trained nurse-midwives staffed nursing stations throughout

the 1960s and 1970s (Rooks, 1997c). An outpost nursing program at Memorial University offered midwifery training from 1979 until 1986 (Plummer, 2000; Relyea, 1992).

In Alberta, a clear division was made between nursing and midwifery after World War I (Plummer, 2000). Nurses aligned themselves with the medical profession and argued that birth should take place in Red Cross Hospitals in remote locations (Plummer, 2000). However, starting in 1919, birthing services were provided by district nurses who had received obstetrical training, to women in isolated areas, where physicians did not work, (Plummer, 2000).

In 1943, the University of Alberta began an outpost nursing program for district nurses working in isolated areas (Plummer, 2000; Relyea, 1992). This program included a course called ‘advanced practical obstetrics for district nurses’ (Plummer, 2000, p. 171). It was not referred to as midwifery, in order to clearly distinguish nursing from midwifery (Plummer, 2000; Relyea, 1992). This program lasted until 1984 (Plummer, 2000; Relyea, 1992) and was followed, in 1987, by a midwifery certificate (Plummer, 2000).

In Toronto during the early to mid-1800s, there were no records of nurses working privately, and Young suggests that midwives may have filled an informal nursing role in private homes (Young, 2010). It is likely that nurses who advertised as “monthly nurses” (Young, 2010, p. 40) or “sick nurses” (Young, 2010, p. 42) in the late 1800s, supplemented their incomes with midwifery services (Young, 2010). Although not formally recorded, Young argues that some nurses may have continued practicing as midwives after adopting the new title of nurse (Young, 2010). In Toronto in 1881, midwives on record totalled six, and this decreased to one midwife on record in 1891, likely due to the increased use of the term ‘nurse’ which made midwifery services invisible (Young, 2010).

In the 1970s, several nurse-midwifery associations were established in Canada. There were three regional nurse-midwifery associations; the Western Nurse Midwives Association (Plummer, 2000; Relyea, 1992), the Ontario Nurse Midwives Association (Plummer, 2000; Relyea, 1992), and the Atlantic Nurse Midwives association (Plummer, 2000). There was also a Canadian National Committee on Nurse Midwives (Plummer, 2000). These associations illustrate a more recent overlapping of identities and histories between the two professions.

### **2.2.2 Ethno-cultural context of midwifery in Canada.**

The cultural context in which birthing care has been provided in communities throughout Canada contributed to the histories of midwives and nurses. For example, there was a common practice of midwives working within their own cultural or religious groups during the early 20<sup>th</sup> century and into the 1950's and 1960's in Canada (Biggs, 2004). These communities included the Japanese community in British Columbia (Biggs, 2004), the Mennonite community in Manitoba (Biggs, 2004; Epp, 2010), and the Hutterite community in Saskatchewan (Biggs, 2004). Orthodox Jewish, Roman Catholic, and Jehovah's Witness communities also made use of midwives within their own religious groups for birthing care (Biggs, 2004). The midwives often provided a variety of health related services to communities (Epp, 2010). However, this was not formally documented due to the marginalisation of these populations and biases in written records which focused on the births of women with British origin (Biggs, 2004).

Indigenous histories of birthing also varied depending on the Indigenous community in which it was practiced (Biggs, 2004). For example, prior to contact with white settlers, Aboriginal midwives were revered for their role as keepers of cultural traditions in British Columbia (Biggs, 2004). In the Prairie Provinces, during the 19<sup>th</sup> and early 20<sup>th</sup> centuries, it was Aboriginal midwives who assisted white women settlers during birth (Biggs, 2004; Relyea,

1992). In Manitoba, there were no specific expectations around birthing, arguably because the nomadic lifestyle of the Inuit required a degree of flexibility for birth to be accommodated (Biggs, 2004). By the 1950's, non-Indigenous midwives were working in northern nursing stations (Plummer, 2000). During the 1960's midwifery and obstetrical training programs were developed for nurses working in northern and remote locations, which were often Indigenous communities, at Dalhousie University, Memorial University, and the University of Alberta (Plummer, 2000; Relyea, 1992). Since the 1980s birth centers have been established in Quebec, Nunavut, Northwest Territories, Ontario, and Manitoba (National Aboriginal Council Of Midwives, 2016) for the purposes of training Indigenous midwives and keeping birthing care within these communities (Plummer, 2000).

### **2.3 Regulation and integration of midwifery in Canada**

The addition of regulated autonomous midwives to maternal-newborn health care in many Canadian provinces over the past two decades has created new opportunities for midwives and nurses to collaborate. The pressure to legislate and regulate midwifery came from consumer groups and the homebirth movement that began in the late 1970s and early 1980s (I. Bourgeault, 2000). The process of midwifery regulation and integration was first undertaken in the province of Ontario.

As the first province to regulate and integrate midwifery, Ontario provided a blueprint for the provinces that followed. Other provinces and territories have had varying histories and successes with regulation and integration. This brief description of the history of these processes in Ontario will provide the context for the regulation and integration of midwifery in other Canadian provinces.

In terms of mobilization and organization of women who were attending births during the 1970s, the Birth Day in Toronto in 1978 was an important event where women began to identify themselves as midwives, due to a presentation by Texan guest speaker Shari Daniels about basic midwifery skills (Bourgeault, 2006). This event was important for many women, however after attending this event one woman, Ava Vosu arranged to go to Texas to learn more about midwifery from Daniels (Bourgeault, 2006). Vosu established the Ontario Association of Midwives upon her return to Canada in 1981 (Bourgeault, 2006). The Ontario Nurse-Midwives Association was formed in 1973 and by 1982 when the Health Professions Legislation Review began, both midwifery organizations had to acknowledge their interest in the formal integration of midwifery into the health care system (Bourgeault, 2006). The Midwifery Task Force of Ontario was created in 1983 as a consumer group in support of midwifery integration (Bourgeault, 2006). Together, the Ontario Association of Midwives and the Ontario Nurse-Midwives Association formed the Midwifery Coalition and with support from the Midwifery Task Force of Ontario, began meetings with the Health Professions Legislation Review about the integration of midwifery (Bourgeault, 2006). In 1985, after much debate, the Ontario Association of Midwives and the Ontario Nurse-Midwives Association merged into the Ontario Association of Midwives (Bourgeault, 2006). After much hard work and negotiation, midwifery was first regulated in Canada in Ontario in 1991, with the legislation becoming effective in 1993 (College of Midwives of Ontario, 2018a; Plummer, 2000; Rooks, 1997c).

The regulation and integration of midwifery in the rest of Canada has been determined provincially, following the governance of health care in Canada. Due to the provincial nature of regulating and integrating midwifery into existing maternity health care systems, there have been variations in when midwifery has been regulated in each province. The integration of midwifery

has also varied between provinces based on how the profession has been regulated, the population needs, and the engagement of provincial governments in the integration initiative.

Currently, midwifery is a regulated profession in all provinces and territories except; the Yukon Territory and Prince Edward Island (Canadian Association of Midwives, 2018b). The regulation for midwifery in Newfoundland and Labrador came into effect in the autumn of 2016 (Association of Midwives Newfoundland and Labrador, 2018). Midwifery was regulated in New Brunswick in 2016, and was implemented at a pilot site in 2017 (Canadian Association of Midwives, 2018b). See Appendix B for more details about when midwifery was regulated in each Canadian province.

The Canadian Association of Midwives was incorporated in 2001 (Association of Midwives of Newfoundland and Labrador, 2018). This organization represents midwifery at the national level and provides advocacy and leadership support to midwives and their provincial associations (Association of Midwives of Newfoundland and Labrador, 2018). The National Aboriginal Council of Midwives was established in 2008 with the support of the Canadian Association of Midwives (National Aboriginal Council Of Midwives, 2012a). The National Aboriginal Council of Midwives represents the professional and education needs of Aboriginal midwives in Canada (National Aboriginal Council Of Midwives, 2012b). Midwives are also represented provincially by provincial associations and they are governed by provincial regulatory bodies.

### **2.3.1 Midwifery education in Canada**

Similar to its leadership role in the processes of regulation and integration of midwifery, Ontario provided a template for the development of educational pathways to midwifery in other Canadian provinces. In determining the educational requirements for midwives in Ontario,

members of the Association of Ontario Midwives recognized the need for formal and standardized education programs (Bourgeault, 2006). The Association of Ontario Midwives also identified a need for the educational program to be degree-based in order to meet standards of credibility with other health professions such as medicine and nursing, and also to ensure that there were pathways to build midwifery scholarship through graduate programs and research (Bourgeault, 2006).

The Association of Ontario Midwives made it clear that prior nursing education would not be a prerequisite for midwifery (Bourgeault, 2006). This was met with resistance from nursing organizations in Ontario who viewed midwifery as an extension of nursing practice, and argued that midwifery should have a nursing education requirement (Bourgeault, 2006). After receiving the approval for the design of the educational approach to midwifery from the provincial government, a call for proposals from potential educational institutions was released. In 1992, a joint proposal from Laurentian University, Ryerson Polytechnic, and McMaster University was successful in its bid to host midwifery education programs in Ontario (Bourgeault, 2006). Midwifery education was first made available in Ontario in 1993 (Bourgeault, 2006; Butler, Hutton, & McNiven, 2016).

Following the initial midwifery education programs at the three institutions in Ontario, other provinces developed their own midwifery education programs. Currently, midwifery in Canada is direct-entry, and therefore prior nursing education is not required (Canadian Midwifery Regulators Council, 2018a). The direct-entry midwifery programs consist of a four year undergraduate degree at a university followed by a certification exam for licensure (Butler et al., 2016; Canadian Association of Midwives, 2018b; Canadian Midwifery Regulators Council, 2018c). Currently, university based midwifery education programs are offered in British

Columbia, Alberta, , Ontario, and Quebec (Canadian Association of Midwives, 2018a). Despite several options for midwifery education programs, there is still a very high demand for admission with approximately 10 applicants for each of the 20 seats for students at the University of British Columbia and 10 applicants for each of the 30 seats at the three universities in Ontario (Butler et al., 2016).

There are also educational pathways for those interested in becoming an Aboriginal midwife in Canada. In addition to the university baccalaureate degree programs, there are community-based education programs available (National Aboriginal Council of Midwives, n.d.). These programs vary from 3 to 6 years and education occurs in one of three communities (National Aboriginal Council of Midwives, n.d.). The three communities with community-based education for Aboriginal midwives are Tsi Non:we lonnakeratstha Ona:grahsta' Aboriginal Midwifery Training Program (Six Nations) in Ontario, Inuulitsivik Community Midwifery Education Program (Nunavik) in Quebec, and Arctic College in Nunavut (National Aboriginal Council of Midwives, n.d.). All three programs incorporate both Western obstetrical knowledge and traditional Aboriginal knowledge and practices (National Aboriginal Council of Midwives, n.d.).

### **2.3.2 Midwifery Care in Nova Scotia**

Nova Scotia has a history of midwifery that can be traced back to the 1600s, when midwives were trained in Paris and sent to New France by the King of France (Biggs, 2004; Relyea, 1992; Rooks, 1997c). Unfortunately, little is known about midwifery amongst the First Nations communities in Nova Scotia (Marion, 2004). In 1872, midwifery legislation was introduced in Nova Scotia and midwifery remained legal until after World War I (Relyea, 1992). Under this legislation, midwives were only required to register if they provided midwifery care

in Halifax, meanwhile, any woman could provide midwifery care if the birth occurred outside of the city (Johns, 1925; Relyea, 1992). Midwifery practice in Nova Scotia became alegal after the dissolution of midwifery certification and registration late in the twentieth century (Marion, 2004). This state of alegality remained until midwifery was regulated in 2009. From 1967 (Plummer, 2000; Relyea, 1992) until 1994 (Plummer, 2000) midwifery training was offered at Dalhousie University through an outpost nursing program (Plummer, 2000; Relyea, 1992).

In 1984 a consumer group called the Midwifery Coalition of Nova Scotia was established with the purpose of ensuring equitable regulated midwifery care for all women and families in Nova Scotia (Marion, 2004; Midwifery Coalition of Nova Scotia, 2018). The Coalition was integral to the regulation of midwifery in 2009. More recently, members have been trying to rally support to put political pressure on the provincial government to expand midwifery services throughout the province (Brown, 2018; Smith, 2017).

Initially, there were challenges with midwifery implementation, and this resulted in the temporary suspension of midwifery services at one of the sites (Taylor, 2012). Due to these initial challenges, the provincial government commissioned an evaluative report by external reviewers to examine midwifery implementation at all three sites (Kaufman et al., 2011; Taylor, 2012). The report was completed in 2011 and the authors noted that at one site, “Interprofessional and interpersonal conflicts were both cause and effect for a widespread loss of trust and confidence among all parties,” (Kaufman et al., 2011, p. 6).

In Nova Scotia, midwifery was implemented at three model sites in 2009 (IWK Health Centre, 2018; Kaufman et al., 2011; Midwifery Regulatory Council of Nova Scotia, 2005) and there are currently 12 midwifery positions in Nova Scotia – six positions at one site and three positions at each of the other two sites. All three sites have offered home birth services, and

nurses and midwives work together during hospital births at all three sites. For home births, Registered Nurses work as second attendants with midwives during home. The second attendant role for home birth is similar to the nursing role during hospital births. Presently, there are no midwifery educational programs in Nova Scotia and midwives receive their education in other provinces.

In January 2018, the midwifery services were suspended at the South Shore site in Bridgewater (Mulligan, 2018; Rankin, 2018). This suspension of midwifery services left 22 women who were in midwifery care to seek care from family physicians and obstetricians in the area, and extinguished the possibility of having a home birth (Rankin, 2018). This left seven of the nine midwifery positions filled during that time, and even those positions were in transition as midwives started or ended their positions at the other two sites. In response to the sustainability challenges that midwives face, which was illustrated with protests (Deveraux, 2018; Janigan, 2018; Leader, 2018) and in coverage by the media, three more midwifery positions were added (Nova Scotia Health Authority, 2018b; Smith, 2018), one new midwifery position to each of the three sites, bringing the total to 12 midwifery positions in Nova Scotia. The midwifery services were restored at the South Shore site with addition of two new midwives, for a total of three midwives, who began accepting clients at the end of August, at that site (Mandel, 2018; Nova Scotia Health Authority, 2018c). The Antigonish site also faced changes in midwifery staffing, with one midwife leaving full time practice, a new midwife beginning in the fall of 2018, and an ongoing search for a third midwife to fill the three midwifery positions available there.

Since the regulation of midwifery in Nova Scotia, Nova Scotian women have not had equitable access to midwifery care (Saulnier, Hemmens, Catano, & Berry, 2010). Women can

only access care if they live in proximity to or are willing to travel to one of the three areas where midwifery services are practiced, and that is only after they have managed to be accepted into care. The demand for midwifery services exceeds the capacity of the midwifery programs. The government has not made a formal commitment to the expansion of midwifery services; despite an assertion by the Minister of Health, in 2016, that the health authority was looking into expanding midwifery services into at least one new site by the end of that year (Elliott, 2015).

#### **2.4 Nursing and Perinatal Care in Canada**

In the early days of nursing, the boundaries between midwifery and nursing were often blurred when it came to birth and birthing, as evidenced by the previous discussion about the history of midwifery in Canada. In 1908, the Canadian Nurses Association was founded and this organization became the national voice for nursing in Canada (Canadian Nurses Association, 2013). Ontario's leadership in nursing registration foreshadowed its leadership role in the regulation of midwifery in that it was the first province to provide registration for nurses. Nurses in Ontario could register for the first time in 1922 (Canadian Nurses Association, 2013). In 1910, Nova Scotia quickly followed, being the first province after Ontario to register nurses (Canadian Nurses Association, 2013). The other Canadian provinces followed these early adopters of nursing registration.

During this time and in the years shortly after the movement to register nurses, educational requirements for nursing became a debate amongst nursing leaders. Specifically, the debate centered around whether nurses should be educated in hospital schools or in a university setting (Canadian Nurses Association, 2013). Up until the late 1990s, nurses were predominantly educated at hospital schools, although university nursing programs were also available (Canadian Nurses Association, 2015). By 1991, the first fully funded PhD program in nursing started at the

University of Alberta (Canadian Nurses Association, 2013). Currently, registered nurses are required to undergo a four year baccalaureate degree in nursing followed by a certification exam (Canadian Nurses Association, 2015). The nursing education programs have both theory and clinical requirements with nursing students obtaining clinical experience prior to independent practice. Once the certification exam is passed, registration with the provincial regulatory organization is permitted.

Perinatal registered nurses accounted for 5.7% (15,010) of all nurses (268,512) in Canada in 2010 (Canadian Nurses Association, 2012). Despite their comparatively small numbers within the whole nursing body, perinatal nurses have a national association called the Canadian Association of Perinatal and Women's Health Nurses which represents the interests of perinatal and women's health nurses. The Canadian Association of Perinatal and Women's Health Nurses was founded in 2011, its predecessor was the Association of Women's Health, Obstetric and Neonatal Nurses Canada (Perry, 2013).

Most nursing education programs include a maternal-newborn health course in their general nursing curriculum, so all registered nurses have basic competencies with this area of nursing practice. The Canadian Nurses Association also offers certification in perinatal nursing for registered nurses who meet experiential and educational requirements (Canadian Nurses Association, 2018). Perinatal nurse certification is not a requirement for practice, but rather an opportunity to engage with a more in-depth knowledgebase in perinatal nursing.

#### **2.4.1 Nursing and perinatal care in Nova Scotia.**

In Nova Scotia, registered nurses are governed by the College of Registered Nurses of Nova Scotia (CRNNS), which regulates the profession within the province. There are three universities that currently offer baccalaureate nursing programs: Cape Breton University,

Dalhousie University, and St. Francis Xavier University. The curricula at these universities include education about perinatal nursing, which may be a standalone course about maternity and newborn health care or imbedded within a course focused on the competencies needed for family, maternal-newborn, and pediatric nursing.

Recognizing a need for perinatal nursing educational opportunities, the Grace Maternity Hospital (now the IWK Health Centre), the Dalhousie University School of Nursing, and the Reproductive Care Program of Nova Scotia formed a partnership that resulted in the creation of the Perinatal Education Partnership Project (PEPP). PEPP was a program that offered baccalaureate level courses to experienced registered nurses working in perinatal care (M.White, personal communication, August 31, 2016). The program received funding support from the Nova Scotia Department of Health and it was offered from 1994 until 1999 (M.White, personal communication, August 31, 2016). Courses were available to nurses throughout the province of Nova Scotia via distance learning (M.White, personal communication, August 31, 2016). Nurses enrolled in the Bachelor of Science in Nursing at Dalhousie University could use the five PEPP courses as credits towards their Baccalaureate degree (M.White, personal communication, August 31, 2016). Nurses who were not enrolled in the Baccalaureate nursing program received a certificate upon completion of the program (M.White, personal communication, August 31, 2016). Nurses were expected to complete the part-time program within 2 years, and of the 94 nurses who registered in the program, 60 completed PEPP (M.White, personal communication, August 31, 2016).

The CRNNS issued a position statement about midwifery and the need to ensure that clarity around scope of practice is maintained between registered nurses and registered midwives in Nova Scotia (College of Registered Nurses of Nova Scotia, 2016). The position statement

clearly articulates the expectation that anyone with dual licenses must fulfill the expectations of the role for that specific instance of employment (College of Registered Nurses of Nova Scotia, 2016). In other words, if a registered midwife were to work casually as a registered nurse, then they must uphold the standards of care and adhere to the scope of practice for the services for which they are employed during that shift or birth or appointment.

The CRNNS has also issued a position statement about registered nurses working as second attendants at home births with midwives which endorses this practice arrangement (College of Registered Nurses of Nova Scotia, 2015). The College is also clear that registered nurses must meet the criteria established by the Midwifery Regulatory Council of Nova Scotia to be second attendants at home birth with midwives (College of Registered Nurses of Nova Scotia, 2015). In addition to this, employers are expected to support this practice arrangement through regularly reviewed policies and education (College of Registered Nurses of Nova Scotia, 2015).

## **2.5 Canadian midwives and nurses**

In Canada, midwives and nurses have a history of overlapping roles, skills, and identities as illustrated in the previous sections (Benoit, 1991; Epp, 2010; Macdonald, 2015; Macdonald et al., 2015; Plummer, 2000; Relyea, 1992; Young, 2010). This has contributed to recent confusion about these similarities. For example, in a systematic review by Macdonald et al. (2015) about the collaborative experiences of midwives and nurses, the authors found that ‘unclear roles’ contributed to challenging collaborative experiences for midwives and nurses. Three of the five studies included in the review were Canadian (2015).

Confusion about roles, skills, and identities was also evident in a document prepared by the Canadian Nurses Association that explored nurse midwifery as a possible advance nursing role (MacDonald, Schreiber, & Davis, 2005). This document was created after midwifery had

been regulated as an autonomous profession in several Canadian provinces. The authors of the report concluded that nurses should support the separate profession of midwifery in Canada and continue to explore ways to assist in an easy transfer between midwifery and nursing education programs (MacDonald et al., 2005). This exploration of ways to incorporate midwifery into nursing, illustrates a recent misunderstanding of the professional boundaries between midwifery and nursing.

There is a documented history of tensions between the midwifery and nursing professions in Canada. For example, nurses supported the medical profession's opposition to midwifery in exchange for support and protection of their own profession (Biggs, 2004). This led to nursing's significant role in the resistance of formal recognition of midwifery as a profession (Biggs, 2004). Nurses prevented midwives from working in cottage hospitals and from practicing in metropolitan areas in Ontario in the early twentieth century (Benoit, 1991) and after World War I, nurses aligned themselves with the medical profession in Alberta arguing that birth should take place in Red Cross hospitals (Plummer, 2000). Rooks suggested that the nursing profession's clear support of a medical model of care for childbirth ultimately influenced the preference to establish autonomous direct-entry midwifery in Canada (1997). A potential contribution to this historical tension between the two professions may be the female dominance in the nursing and midwifery professions in Canada (Adams & Bourgeault, 2004).

In Canada, midwifery and nursing are both female dominated professions (Adams & Bourgeault, 2004). Nursing has been female dominated and nurses have been historically included health care providers in the health care system. Midwifery has been female dominated and, until it was regulated, was often practiced at the margins of healthcare, particularly in remote or isolated areas (Benoit, 1991; Biggs, 2004; Plummer, 2000; Relyea, 1992). Midwifery

originated as a site of feminist resistance against the medicalization of childbirth (Shaw, 2013). This feminist stance was more radical and in direct opposition to existing institutional hierarchies. Midwifery was not part of the dominant discourse around childbirth and was therefore excluded from the socially constructed and respected institution of medicine (Shaw, 2013). Whereas, nursing was formally included within the respected institution of medicine. The different experiences of professional inclusion for each of these two professions have had lasting implications on regulation and practice. It is these different professional histories and how they have and continue to influence collaboration between midwives and nurses that is of interest.

Despite the history of tensions between midwifery and nursing, and current research evidence that suggests that midwives and nurses are having some negative collaborative experiences, there have been policies created that rely specifically on the collaboration between midwives and nurses. Most Canadian provinces that have regulated midwifery in Canada have policies or official documents that outline the role and criteria of non-midwife second attendants for home births. Interestingly, Registered Nurses or Obstetrical Nurses are listed amongst several health care providers who could be potential second attendants at home births with midwives. The provinces that include nurses in their second attendant policies are; Saskatchewan, Manitoba, Nova Scotia, and British Columbia (College of Midwives of British Columbia, 2018; College of Midwives of Manitoba, 1999; Midwifery Regulatory Council of Nova Scotia, 2017a; Saskatchewan College of Midwives, 2017). Ontario does not specify any particular types of health care providers that may suit the second attendant role but lists criteria for this role and reminds the reader that the Ontario model of midwifery care requires two midwives in attendance at each birth when a midwife as primary care provider (College of Midwives of Ontario, 2018b). The Northwest Territories does not specify any specific health care providers

for this role either, instead they list the criteria required. Newfoundland and Labrador does not have a policy in place, however, nurses were listed as potential second attendants at home birth in a document that provided recommendations for the integration of midwifery into the maternal-newborn health care of that province (Kaufman & MacDonald, 2013). At this time it is unclear what Nunavut has in place in terms of a second attendant policy for homebirths and a search for such a policy for the province of Quebec yielded no results. The existence of these policies that list nurses as potential second attendants for home births suggests that collaboration between midwives and nurses is important in order to build capacity for midwifery care in Canada. These second attendant policies also make it clear that nursing can have a role in midwife-led models of birthing care.

A qualitative approach that embraces the complexities described previously is necessary for this study. It is therefore imperative to engage in this research with a philosophical lens that can tend to the historical, social, and institutional contexts, relations of power, and influences of gender that contribute to current understandings and experiences of collaboration between midwives and nurses in Nova Scotia. Feminist poststructuralism provides a paradigm to engage with the complexities of this research topic. It is also essential to examine the multi-stakeholders' perspectives that are at play in this complex phenomenon of study, thus the choice of a qualitative case study approach by Stake (1995) that used multiple sources of data to paint an in-depth portrait of the given phenomenon (collaboration).

## **2.6 Beliefs and values about birth**

There are a variety of beliefs and values about birthing (Macdonald, 2015; Macdonald et al., 2015). An exploration of quantitative Canadian literature about the beliefs and values that health care providers have about birthing, uncovered several variations (Blais et al., 1994; Brown

et al., 2009; Klein et al., 2009, 2011; Kornelsen, Dahinten, & Carty, 2003; Liva, Hall, Klein, & Wong, 2012; McNiven et al., 2011; Smith et al., 2009; Vedam et al., 2012). A closer examination of these values and beliefs will be provided below.

Multiple maternity health care professionals were included in the Canadian studies about beliefs and values in birthing, including; nurses (Brown et al., 2009; Klein et al., 2009; Kornelsen et al., 2003; Liva et al., 2012) and midwives (Klein et al., 2009; McNiven et al., 2011; C. Smith et al., 2009; Vedam et al., 2012). Topics with variations in beliefs and values included; midwifery care (Klein et al., 2009; Vedam et al., 2012), collaboration (Brown et al., 2009; Klein et al., 2009; Kornelsen et al., 2003), safety of home birth (Klein et al., 2009; McNiven et al., 2011; Vedam et al., 2012), and women's role in decision making (Klein et al., 2009). There were also a variety of beliefs and attitudes about birthing interventions (Klein et al., 2009; Liva et al., 2012; McNiven et al., 2011). The variations in beliefs and values were both between and within various professions. The findings of a qualitative systematic review that supported the theme of negative experiences of collaboration, between midwives and nurses, included; lack of clear roles, distrust, and lack of professionalism or consideration (Macdonald et al., 2015).

With regards to beliefs and attitudes about birthing interventions, Klein et al. (2009) conducted a study of Canadian midwives, nurses, doulas, family physicians, and obstetricians that examined provider attitudes about labour and birth. Provider beliefs varied for interventions such as electronic fetal monitoring, epidural analgesia, and episiotomy. For routine electronic fetal monitoring, all participants in the study indicated that they were not supportive of the routine use of this technology, with the exception of seventy-eight obstetricians (out of 2,583 participants) who favoured the routine use of this assessment technique (Klein et al., 2009). In the case of epidural analgesia, obstetricians favoured their use, however there was variation

within this group (Klein et al., 2009). Midwives and doulas were most strongly against the use of epidural analgesia, although there were 13 midwives (of 2,583 participants in the study) who were supportive of this intervention (Klein et al., 2009). Family physicians and nurses were not as strong in their opinions against the use of epidural analgesia (Klein et al., 2009). Finally, Klein et al. (2009) found that all the participants were against the use of episiotomy, however there were small numbers of participants from each of the provider groups who were supportive of its use.

With regards to providers' beliefs about the safety of homebirth, Vedam et al. (2012) found that midwives, obstetricians, and family physicians all believed their views were evidence-based. Midwives (97.0%) believed that home birth was as safe as hospital birth, while both family physicians (83.9%) and obstetricians (81.8%) believed that home birth was less safe than hospital birth (Vedam et al., 2012). Interestingly, in these findings all three provider groups of participants believed their beliefs were informed by evidence. This raises the larger question about what constitutes evidence and who determines what evidence is - two issues which are difficult to explore using quantitative methods.

There were two limitations of these quantitative studies. The use of quantitative data collection techniques, such as likert scales, limits the ability to gain a deep understanding of the contexts that influence the attitudes and beliefs of care providers. Secondly, quantitative methods such as questionnaires and likert scales, limit studies to prescribed questions that do not necessarily leave room for participants to voice additional issues of importance.

## **2.7 Collaboration**

Collaboration in health care is not a new process and it is becoming increasingly important in an era of efficiency, cost-effectiveness, and the constant need to improve health

outcomes. Yet the limited research about nurses and midwives collaborating is interesting because of the similarity in roles of these two professions (Benoit, 1991; Epp, 2010; D. Macdonald, 2015; D. Macdonald et al., 2015; Plummer, 2000; Relyea, 1992; Young, 2010) and their close, continual physical proximity to one another, when providing care to women during labour and birth. The Canadian Nurses Association, Canadian Association of Midwives, and Canadian Association of Perinatal and Women's Health Nurses (2011), issued a joint position statement about the importance of strong partnerships between midwives and nurses. In this statement, these leading professional organizations articulated that "Midwifery and nursing are distinct and complementary professions, each providing specialized knowledge and expertise," (Canadian Nurses Association, Canadian Association of Midwives, & Canadian Association of Perinatal and Women's Health Nurses, 2011, p. 1).

This joint statement between all three professional associations clearly identified shared professional values and beliefs about the provision of maternal-newborn health care in Canada. The statement also illustrates a commitment to unity and support from all three professional associations for a definition of collaboration established by the National Primary Maternity Care Committee during the Multidisciplinary Collaborative Primary Maternity Care Project (Society of Obstetricians and Gynaecologists, 2006). This definition describes collaboration as,

Collaborative woman-centered practice designed to promote the active participation of each discipline in providing quality care. It enhances goals and values for women and their families, provides mechanisms for continuous communication among caregivers, optimizes caregiver participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines. (Society of Obstetricians and Gynaecologists, 2006, p. 15)

The commitment to collaborative relationships, demonstrated by the collectively endorsed joint position statement and unified support for a definition of collaboration by the national associations that represent Canadian midwives and nurses illustrates recognition that collaboration between these two provider groups is important for Canadian maternal-newborn health care. This commitment to collaboration between midwives and nurses provides a starting point for midwives and nurses who are new to working together due to the expansion or integration of midwifery services into areas that did not previously have midwifery services. It is also a point of maintenance, whereby midwives and nurses can remind themselves of the commitment made by each of their professional associations to collaborative maternal-newborn health care.

This record of commitment to collaboration between midwives and nurses is relevant given the challenges of collaboration generally, and more specifically in the provision of maternal-newborn health care. In Canada, researchers identified several benefits, and barriers to collaboration in maternity care in a qualitative study using semi-structured interviews (Peterson et al., 2007). Twenty-five participants representing six national health professional associations related to maternal-newborn health in Canada were interviewed (Peterson et al., 2007). Researchers sampled participants from national associations representing midwives, nurses, obstetricians, and physicians (Peterson et al., 2007). Benefits of collaborative care were identified as; a) addressing the shortage of maternity care providers, and b) improving maternity through improvements to access, choice, and appropriate care providers (Peterson et al., 2007). Barriers to collaboration included; a) structural barriers such as payment, liability and insurance b) interdisciplinary rivalry such as protecting one's professional turf, and lack of respect (Peterson et al., 2007). In addition to the benefits of and barriers to collaboration, the researchers

uncovered that participants were concerned about the ways in which collaboration in maternal-newborn health care is implemented (Peterson et al., 2007). This included concerns about women and family centered care, flexibility, and continuity of care providers (Peterson et al., 2007). Participants in this study echoed the commitment to collaboration in Canadian maternal-newborn health care (Peterson et al., 2007) articulated in the joint position statement issued by the Canadian Nurses Association, Canadian Midwives Association, and the Canadian Association of Perinatal and Women's Health Nurses (2011). The barriers to collaboration identified by the participants in this study were also congruent with; the synthesized finding of negative collaborative experiences between midwives and nurses in the previously mentioned qualitative systematic review (Macdonald, 2015; Macdonald et al., 2015), the barriers of collaboration between midwives, nurses, and physicians identified by researchers in a case study conducted in Quebec (Behruzi, Klam, Dehertog, Jimenez, & Hatem, 2017), and the barriers of collaboration between midwives and health visitors (public health nurses) identified by researchers who conducted a systematic review of qualitative and quantitative evidence (Aquino, Olander, Needle, & Bryar, 2016).

According to Smith et al. (2009) in a study of midwives, family physicians, and obstetricians in Ontario about models of maternity care, the two barriers to collaboration identified by each professional group of participants were similar and different. For example, midwives identified varied philosophies of care and resistance to change as barriers to collaboration (Smith et al., 2009). Both family physicians and obstetricians identified varied philosophies of care and liability and insurance issues as barriers to collaboration (Smith et al., 2009). Interestingly, all three provider groups agreed that the different philosophies of providers was a barrier for collaboration. The midwives saw resistance to change as a barrier, yet the

family physicians and obstetricians identified insurance and liability issues as a barrier to collaboration.

Negative experiences of collaboration (Macdonald, 2015; Macdonald et al., 2015) and barriers that include interdisciplinary rivalry such as protecting one's professional turf, and disrespect (Peterson et al., 2007) imply that power is an issue for health care providers engaged in collaboration. Likewise, that midwifery and nursing are both female dominated professions (Adams & Bourgeault, 2004) within the larger venue of traditionally male dominated medicine. Further exploration is needed in order to understand how issues of power and gender are negotiated between midwives and nurses during collaboration, within the context of the medical system. In order to adequately understand the phenomenon of collaboration between midwives and nurses, consideration of the concepts of power and gender and how these concepts intersect will be essential.

### **Summary**

In summary, the uniqueness of the Canadian model of midwifery care, the collaboration occurring between midwives and nurses, and the identified lack of research about collaboration between midwives and nurses collectively warranted further exploration of collaboration between midwives and nurses in Canada. The overlapping histories, similarities in roles and skills, variations in attitudes and beliefs about birth, the historical and ongoing tensions between the two professions, and the clearly identified gap in the literature, supported the need to explore how these two professions currently experience and understand collaboration. This feminist poststructuralist case study included the perspectives of midwives and nurses, mothers, administrative stakeholders, and health care provider colleagues in Nova Scotia. The findings of this study have the potential to support and strengthen existing collaborative birthing care services and inform the development of future collaborative maternity care practices in Nova

Scotia and in Canada. This research contributes to the limited qualitative literature about collaboration between midwives and nurses, adding to the number of studies that have explored collaboration between these two provider groups.

### **Chapter 3: Theoretical Perspectives**

In this chapter, I will describe the philosophical and theoretical perspectives that will guide this proposed research study. First, I will discuss my philosophical perspective or worldview (i.e. my paradigmatic location). Secondly, I will discuss feminist poststructuralism including in-depth descriptions of feminism, intersectionality, and poststructuralism. Finally, I will conclude with a description of feminist poststructuralism which integrates these perspectives, and specifically the combination of intersectionality and poststructuralism.

#### **3.1 Paradigms**

A paradigm is a world view (Guba & Lincoln, 1994; Polit & Beck, 2012), it is the way you consider the world around you and your place within it. In order for me to locate myself within a paradigm, I first had to understand what my ontological and epistemological positions were. Ontology refers to the nature of reality and epistemology refers to how knowledge is known (Creswell, 2013; Guba & Lincoln, 1994; LoBiondo-Wood, Haber, Cameron, & Singh, 2013; Polit & Beck, 2012). Ontologically, I believe in multiple realities and multiple truths. Epistemologically I believe that knowledge is acquired in multiple ways. I have located myself within a spectrum of paradigms.

There are many paradigms which may have similar names and similar definitions. Guba and Lincoln (1994) present four paradigms as separate entities and for the purpose of this chapter I will use their identification of these four worldviews. The four paradigms are; positivism, post-positivism, critical theory, and constructivism (Guba & Lincoln, 1994). While there are similarities between positivism and post-positivism and similarities between critical theory and constructivism, the authors' presentation of them imply that a researcher needs to locate oneself within only one paradigm. Choosing one paradigm in which to locate myself troubled me

because I identify with aspects of two of Guba and Lincoln's suggested paradigms. Fortunately, Guba and Lincoln (1994) recognized that the four paradigms could be grouped into two pairs, each pair sharing congruent epistemologies and ontologies. These ontological and epistemological similarities allow for fluidity within the paradigms that form a pair. Positivism and post-positivism form a pair of ontologically and epistemologically congruent paradigms. Critical theory and constructivism form the other pair of epistemologically and ontologically congruent paradigms, and it is within these two paradigms that I situate myself.

### **3.1.1 Critical theory and constructivism.**

I situate myself primarily in the critical theory paradigm, and also in the constructivist paradigm. Due to their similar ontologies and epistemologies, I am able to situate myself within a spectrum where these two paradigms can be fluid and overlap. I am drawn to critical theory because of the emphasis placed on the historical and contextual factors that influence our changing understandings of reality (Guba & Lincoln, 1994). Critical theory contends that there are multiple unfixed realities. It focuses on critiquing and transforming historical and contextual influences, with the aim of achieving emancipation from the constrictions of these influences (Guba & Lincoln, 1994). In other words, critical theory is concerned with change through the use of critique. My belief in the need to critique and transform current social and historical power imbalances in order to emancipate populations from health care inequities would be an example of how I employ a critical theory perspective.

The constructivist paradigm is congruent with the critical theory paradigm in that it also recognizes multiple, constructed realities (Guba & Lincoln, 1994; LoBiondo-Wood et al., 2013). One of the main differences between critical theory and constructivism is that constructivism does not share the aim of using critique for transformation and emancipation (Guba & Lincoln,

1994; LoBiondo-Wood et al., 2013). Instead, constructivism focuses on the individual and the importance of understanding that one's constructed reality can change, and that there is not one universal reality that everyone subscribes to (Guba & Lincoln, 1994; LoBiondo-Wood et al., 2013). Constructivists believe that realities are constructed, and the construction of these realities can be influenced by society, experiences, and thoughts (Guba & Lincoln, 1994). These constructions can be mutually held between people or groups of people and they can also change (Guba & Lincoln, 1994). My belief that gender is socially constructed and not defined by biological traits is an example of how I employ a constructivist paradigm.

### **3.1.2 Feminist Poststructuralism.**

Feminist poststructuralism is a philosophical perspective and a methodology that combines feminist and poststructuralist theories. Ontologically, feminism and poststructuralism both recognize the existence of multiple realities and aim to identify and provide space for the voices of the invisible or marginalized to be included in mainstream discourses. Epistemologically, they both recognize that what is known is shaped by experiences, power, and contexts.

Both feminism and poststructuralism can be understood as critical theories because they are both driven by ethics of critique, transformation, and emancipation. For example, feminists used critique to further the political agenda for women's reproductive rights. The unified critique of the medicalization of birth by feminists and midwives in Ontario transformed access to reproductive care and resulted in the regulation of midwifery in that province (I. Bourgeault, 2006), followed by similar feminist movements and regulation of midwifery in other Canadian provinces.

A poststructuralist example of using critique to challenge current understandings of unsafe sexual practices between HIV positive men who have sex with men can be found in the work of Holmes and Warner (2005). Through 18 interviews with men in five cities they found that for the men who engaged in unprotected sex with HIV positive men, this act had profound meaning beyond the potential health implications of this conduct (Holmes & Warner, 2005). Understanding these practices provided insight into how public health strategies that encourage safe sex through education marginalized this population (Holmes & Warner, 2005). This study also highlighted the need for dialogue about the intentionality of sexual practices in order to include people who are marginalized with regard to mainstream public health HIV education strategies (Holmes & Warner, 2005). In this example, poststructuralism provided the first step, critique, towards transforming practices.

Feminism and poststructuralism also have constructivist perspectives. Both feminism and poststructuralism recognize that realities are constructed and change depending on time, context, experience, and power. In poststructuralism this is evidenced by a recognition that discourses are socially, historically, and institutionally created and maintained (Weedon, 1987). For example, in a study by Aston et al. (2016), of 16 public health nurses, 16 new mothers, and 4 managers, the authors found that the discourses about health outcomes for the interviewed participants did not correspond to the measurable health outcomes situated within the hegemonic medical discourse. In this study, health outcomes for new mothers that were identified by mothers and the public health nurses that work with them included; confidence, reassurance, normality, and less stress. These health outcomes did not coincide with health outcomes that are measured quantitatively and found in medical discourses which are hegemonic in health research (2016). Aston et al. (2016) illustrated that there were at least two socially constructed discourses about health

outcomes for new mothers. The authors of this study illustrated how the current dominant discourse marginalized the health outcomes identified by the mothers and public health nurses (2016).

Different understandings of the process of childbirth provide examples of how childbirth discourses, and the practices they inform, are socially constructed. For example, there are often two identified discourses associated with childbirth, one recognizes childbirth as a normal physiological process where the other discourse focuses on childbirth as a pathological event. Often, these two discourses are associated with the midwifery (physiological) approach and the medical (pathological) approach to childbirth. In Canada, feminists aligned themselves with midwives and the physiological approach to birth during the process of midwifery regulation in Ontario (I. Bourgeault, 2006). The primary reason for this was the recognition that midwifery offered women care that; included them, respected their bodies and the capabilities of their bodies, and recognized women's right to make their own reproductive choices (Shaw, 2013). The midwifery discourse that supports childbirth as a physiological process is in conflict with the medical discourse that supports childbirth as a pathological process, requiring management and interventions (Shaw, 2013). A midwifery discourse can also be found in many cultures where the dominant discourse supports childbirth as a healthy life event in the course of a woman's life (Etowa, 2012). For many women, a childbirth discourse extends beyond whether birth is a physiological or pathological event into the realm of childbirth as a spiritual event. For example, Etowa (2012) found that African-Canadian women in Atlantic Canada described childbirth as a spiritual journey. For the participants in Etowa's (2012) study, the dominant childbirth discourse was reflected as childbirth having great spiritual importance. Each of these discourses have been socially constructed by the experiences and socialization of care providers, historical contexts,

culture, and power. The medical discourse of childbirth has been the dominant childbirth in Canada and the regulation of midwifery has provided a legitimate challenge to this discourse (Shaw, 2013).

### ***3.1.2.1 Concepts.***

There are several concepts that are relevant to feminist poststructuralism. In this section, I will introduce several key concepts relevant to this philosophical perspective and this proposed research study. The concepts include; power, discourse, gender, intersectionality, language and text, surveillance, governmentality, and subjectivity and subject positions.

Power is a central concept for feminist poststructuralism. In feminism, patriarchal power requires change in order for equality between men and women to occur (Weedon, 1987). In poststructuralism, power is understood as ‘relations of power’, where it is a dynamic in a constant state of change existing everywhere (Foucault, 1982; Weedon, 1987). It can also be productive in terms of how it allows certain knowledge to be created and known (Cheek, 2000). Feminist poststructuralism provides a perspective that focuses on the critique and transformation of patriarchal power relations while maintaining an understanding that multiple forms of power exist everywhere and in many contexts.

For this study, discourse is a concept that originates in poststructuralism. Discourse can be understood as a group of common assumptions that are often invisible because they contribute to knowledge that we take for granted (Cheek, 2000). According to Weedon (1987), discourses can be found in social institutions and are demonstrated through writing, speech, and social practices. They are constantly in competition with each other to be the dominant discourse (Weedon, 1987). Examples of discourses of interest for this proposed study included; patriarchy,

medicine, midwifery, and equity. Additional discourses and multiple perspectives within them were also identified through data analysis (Weedon, 1987).

Gender is a socially constructed concept. For Butler (2007), this social construction is based on traditional understandings of biological sex difference. Butler also described gender as performative, with a meaning that is not fixed (2007). According to Weedon (1987), gender is socially constructed with multiple and various defining features depending on the discourse in which it is located.

Intersectionality is both theory and praxis (Collins & Bilge, 2016). The concept is often attributed to the work of Black feminists in the United States in reference to how the intersection of racism and sexism, that affected Black women, was not captured by White feminist theory (Collins & Bilge, 2016; Crenshaw, 1989). The concept has come to include the multiple forms of discrimination and places a clear emphasis on the intersection of many contextual factors, including; class, religion, culture, race, gender, and others (Collins, 1998).

Language is used to convey the meanings of experiences (Weedon, 1987). Understanding that there are many languages and meanings illustrates the difficulties in fixing one universal meaning to any aspect of a language (1987). Language can be expressed through texts which can take the forms of a conversation, artwork, or an article (Cheek, 2000). Understanding that languages have many meanings, expressed in multiple modes of text, will be important for the collection and analysis of data for this proposed research.

Surveillance is a concept used by Foucault (1975) to describe how the act of observation and documentation of observations can be used to govern individuals and communities (Cheek & Rudge, 1994). Eventually, when an individual or group of people is under constant surveillance, their behaviour and conduct becomes aligned with the expectation of the

person/people/institution in power (Cheek & Rudge, 1994; Foucault, 1975). The promise of disciplinary actions and not knowing exactly when one is under surveillance contributes to this adherence to behavioural expectations.

Governmentality is a concept that relates to the ability to direct the actions of others (Foucault, 1982). Power is often associated with the ability to direct the actions of others, but Cheek and Porter (1997) noted that there is power in deciding whether one submits to being governed or resists it. Governmentality is often attributed to institutions or societal structures that aim for all individuals to behave or conduct themselves in ways defined as appropriate by those same institutions or societal structures.

A subject position is how an individual is governed by a particular discourse (Weedon, 1987). It involves one's ability to decide where they will be positioned within a discourse. Subject positions that are similar can form a collective which determines the dominance of a discourse.

### **3.2 Feminism**

Generally, feminism is concerned with power relations as they relate to gender. Specifically, feminism began as a political movement concerned with challenging the patriarchal oppression of women and the power relations that support this form of oppression (Weedon, 1987). Nadasen in (Laughlin et al., 2010) described feminism as, “.. a political program working to empower women, to ensure them autonomy and control over their lives in a way that does not impede the autonomy or contribute to the exploitation of other women,” (2010, p. 103). I would also add that for many feminists, and particularly for those who employ intersectionality, the desire not to impede autonomy or contribute to exploitation is not limited to women but extends to all people (Collins & Bilge, 2016).

Feminism has also entered academic institutions (Collins & Bilge, 2016), where feminist theories have been created and expanded with the purpose of addressing gender equality. Feminism has been most readily found in Women's Studies and Gender Studies departments in universities (Collins & Bilge, 2016). This formal migration of feminism to the Academy has also contributed to research, resulting in innovative feminist methodologies and recognition that gender is an important aspect of social science.

Feminists have argued that western society is based on a system that is rooted in patriarchy, resulting in significant implications for women and their experiences in the world (Weedon, 1987). Patriarchy is understood to be the subordination of women's rights and opportunities in favour of the rights and opportunities of men (Weedon, 1987). These implications have manifested themselves in unequal opportunities and unequal behaviour expectations for women. Feminism is emancipatory in that it aims to liberate women from patriarchal oppression, transforming society, and ultimately ending patriarchy (Weedon, 1987).

### **3.2.1 Types of feminism.**

While the term feminism is often used in a general sense, there are multiple forms of feminism which focus on and emphasize different approaches and understandings about oppression and emancipation from patriarchy (Campbell & Wasco, 2000). According to Weedon, the three main feminisms are; liberal feminism, radical feminism, and social or Marxist feminism (Weedon, 1987). These three forms of feminism serve as examples of variations in feminist thought and theory, but they are not an exhaustive list of feminist approaches.

Liberal feminism has advocated for women's equality in existing institutions and systems. The goal of liberal feminism is not to reinvent institutions or the system, but to make changes in order to equalize women's place within the current institutions and systems

(Campbell & Wasco, 2000; Weedon, 1987). Equality sought by liberal feminists is based on an approach where the similarities between men and women are emphasized and the biological differences overlooked (Weedon, 1987). This approach ignores the importance of the contextualization of women's experiences and understandings of oppression, maintaining that women and men share the same needs and experiences.

Radical feminism has advocated for radical changes to current institutions and systems. In fact, radical feminists have argued that women's equality will not be attained until alternate institutions and systems replace the current ones (Campbell & Wasco, 2000). According to Weedon (1987), there is a recognition of the biological differences between women and men, and a belief that the biological capability of women should be celebrated. One critique of this approach is the essentialist perspective that it offers, assuming that all women have the same biological capabilities or potential biological capabilities (1987). This assumption leads to the exclusion of women who, for varying reasons, do not (1987).

Socialist feminism places economic and class influences as central to women's inequalities (Campbell & Wasco, 2000). Marxism has had a deep influence on socialist feminism and the role of capitalism on multiple inequalities experienced by women (Campbell & Wasco, 2000). For socialist feminists, there is an emphasis placed on the social construction of womanhood and there is an understanding that the meanings of womanhood are not static (Weedon, 1987). Socialist feminists take into account individual oppressions such as race, class, and gender, and the historical location from which those oppressions originate (Weedon, 1987).

Although these are three well known forms of feminism, it is important to understand that there are endless variations of perspectives and forms of feminisms. There are also many other types of feminisms, each influenced by many contextual factors, history, and time (Campbell &

Wasco, 2000). Describing only three types of feminisms implies that feminists can be categorized neatly and without accounting for the complexity of intersecting discourses – they cannot. This is an important point as the feminist approach I used for this study aimed to account for the complexities of the intersecting discourses of gender, discrimination, and oppression.

Further complicating our understandings of feminisms are the references to different waves of feminism, where feminism can be understood not only through the epistemological and ontological perspectives as described previously, but also through the context of time. The concept of different waves of feminism originated within the North American context and this categorization of various feminist time periods has been criticised for not including the experiences of women from multiple, varied and intersecting social positions (Hewitt, 2012; Laughlin et al., 2010). The concept of the waves of feminism has also been criticised due to the presentation, in chronological order, of the feminist movement as if specific feminist issues were only of concern during discrete and defined historical periods of time (Hewitt, 2012)

One noteworthy critique of North American feminism has been that it was created by white women, and only reflected their values and experiences, which excluded the diversity of women's voices and experiences (Collins & Bilge, 2016; hooks, 1984, 1994). Black feminists argued that the multiplicity and diversity of women's experiences and contexts need to be accounted for in order to achieve equality and emancipation from patriarchy (Crenshaw, 1989; hooks, 1984; Lorde, 1984). For bell hooks, "Feminism as a movement to end sexist oppression directs our attention to the systems of domination and the inter-relatedness of sex, race, and class oppression," (1984, p. 31). An in-depth understanding of feminism is important for this study because midwifery and nursing are both professions that are predominantly practiced by women. Extending this gendered lens to include the multiple contexts that influence women's

experiences reflects an attempt to remain mindful of the many intersecting factors that influence how midwives and nurses collaborate. It is within this context that I will introduce intersectionality, a feminist approach that accounts for the plurality and complexity of contexts that inform women's experiences.

### **3.3 Intersectionality**

Intersectionality has been described as feminist 'best practice' (Bilge, 2010, p. 58) and as the 'gold standard' (Nash, 2008, p. 2) within feminism. The term intersectionality has many definitions depending on who one speaks to. There is general confusion as to whether intersectionality is a paradigm (Bilge, 2010; Carbin & Edenheim, 2013; Van Herk, Smith, & Andrew, 2011), a theory or a framework (Carbin & Edenheim, 2013), a methodology (Naples, 2009), or a political movement (Carbin & Edenheim, 2013; Davis, 2008). Intersectionality has provided a frequently used theory, framework, and methodology for feminists (Carbin & Edenheim, 2013; Davis, 2008; May, 2014; Nash, 2008) and it is therefore understandable that there is confusion about what it is and what it does. Davis describes intersectionality as, "...the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power" (2008, p. 68). This definition of intersectionality illustrates its inclusiveness of multiple perspectives, multiple contexts and a space for analyzing their multitude of meanings. While this definition explicates the components and interactions related to intersectionality, it does not impart what intersectionality does.

Collins and Bilge (2016) suggest that intersectionality is both a critical theory and a critical praxis. This means that intersectionality can be used to critically analyze the world we live in as it relates to the intersections of many social positions and it can be used in practice

(praxis) as an empowerment tool for social justice (Collins & Bilge, 2016). These authors offer an understanding of intersectionality that bridges the dichotomy between intersectionality as theory and intersectionality as praxis (Collins & Bilge, 2016). They also suggest that the ability of intersectionality to be applied theoretically and in praxis makes it uniquely suitable for disciplines, such as nursing, which require engagement in both theory and praxis (Collins & Bilge, 2016).

### **3.3.1 Definition of intersectionality.**

The definition of intersectionality that guided this study is one that has been created by Collins and Bilge and presented in their comprehensive and recently published book titled *Intersectionality* (Collins & Bilge, 2016),

Intersectionality is a way of understanding and analyzing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves (Collins & Bilge, 2016, p. 2).

This definition of intersectionality highlights the importance of understanding power relations through intersecting factors that influence how power is used. This is particularly relevant for professional collaboration between health care providers who have many factors that intersect and influence how they work together. Intersectionality tends to plural meanings of gender and

other contextual factors. Using intersectionality as an analytic tool for this research provided a way to account for multiple contextual factors, including gender, that shape understandings and experiences. Intersectionality supported research inquiries regarding the historical, social, and institutional influences on collaboration between midwives and nurses, and assisted with the identification of where some of these influences may overlap with the influence of gender.

### **3.3.2 History of intersectionality.**

The history of intersectionality is not one that can be traced in a linear and organized fashion (Collins & Bilge, 2016), given the complexities involved in describing the history of feminism. That said, we can trace the core ideas of intersectionality to the fact that mainstream feminism from the 1960s until the 1980s did not account for the many intersecting systems of power that affected the lives of women from a variety of backgrounds. The core ideas of intersectionality can be traced to Black feminists in the United States (Carbado, 2013; Crenshaw, 1989; hooks, 1984; Lorde, 1984) who argued that their experiences as Black women were not reflected in mainstream feminism. Collins and Bilge identified several Black feminists as having contributed to these initial core ideas of intersectionality through seminal pieces of writing in the 1970s including: Toni Cade Bambara, Francis Beal, the Combahee River Collective, June Jordan, Audre Lorde, and Angela Davis (2016). Collins and Bilge (2016) describe six core ideas of intersectionality; a) social inequality b) relationality c) power d) social context e) complexity f) social justice. It is these six core ideas of intersectionality to which these Black feminists, and others, made initial contributions. Collins and Bilge (2016) also point out that other groups of marginalized women, such as Chicanas and Latinas, Native American women and Asian-American women, were also at the forefront of intersectionality work around the same time. In

addition, marginalized women in other countries also contributed to intersectionality work (Collins & Bilge, 2016).

Kimberle Crenshaw is the name most attributed to the term, intersectionality (Carbado, Crenshaw, Mays, & Tomlinson, 2013; Carbin & Edenheim, 2013; Collins & Bilge, 2016; Yuval-Davis, 2006). She used it first in an article that critiqued the judicial limitations which limited discrimination claims to single-axis patterns of thought (Crenshaw, 1989). Specifically, the legal system was unable to account for claims submitted by Black women who argued that their experiences as Black women lead to mistreatment and discrimination (Crenshaw, 1989). Instead the law required that claims were submitted as either women or Black people, but not for Black women as a group, who argued that their experiences of discrimination were a product of the intersection of both race and gender (Crenshaw, 1989).

Intersectionality offers an inclusive approach to account for the complexities that influence collaboration between midwives and nurses. It highlights social positions and contexts as intersecting influences in an individual's life and provides an opportunity to understand and articulate how these influence and impact professional and personal lives. Although the majority of midwives and nurses in Canada are women, I would be remiss to name gender as the singular social position that informs their collaborative experiences. Intersectionality provides a means to develop an in-depth understanding of how multiple social positions may be influencing collaboration between midwives and nurses in Nova Scotia.

### **3.3.3 Critiques of intersectionality.**

The strength of intersectionality is its inclusiveness of multiple contexts, experiences, and understandings has been criticized as a weakness of this perspective. More specifically, there have been several critiques of intersectionality. Two critiques will be explored in this section

including; intersectionality as an anything goes approach and intersectionality's lack of disciplinary allegiance.

Critics have expressed frustration with the refusal of an essentialist categorization of women and their experiences, stating that intersectionality's inclusion of many categories of difference removes gender as the central and unifying aspect of feminism (May, 2014).

Intersectionality eventually expanded to include how other contextual influences such as class, religion, culture, race, and gender (Collins, 1998) affected experiences of discrimination. And today intersectionality is not limited to a specific list of social positions or contextual factors that determine whether intersectionality can be applied (Bilge, 2013). Instead, it is decidedly inclusive of many social positions which contributes to the development of creative and innovative intersectional approaches in both theory and praxis (Davis, 2008).

Cho, Crenshaw, and McCall (2013) have observed that critiques about the scope of applying intersectionality to other fields reflects similar discomfort expressed by courts when Black women initiated discrimination claims based on the intersection of race and gender. The irony here is the need for some feminists to categorize intersectionality in ways that intersectionality itself argues against (Davis, 2008). For Davis (2008), intersectionality is necessarily open and ambiguous, allowing for discovery and an understanding of the complexities and contradictions in the world. Ultimately, intersectionality is a work in progress (Carbado et al., 2013) and its ambiguity, and openness to a plurality of contexts and experiences located in the intersectional perspective compliments the poststructuralist approach that I will discuss in the following section.

### **3.3.4 What does intersectionality contribute to this research?**

First and foremost, intersectionality offered an inclusive perspective that accounted for the myriad of social positions and contexts that affect one's experience in the world. The overlapping histories, separate educational systems, socialization into different childbirth discourses, and similar roles and practices made it necessary to employ intersectionality for this study about collaboration between midwives and nurses in Nova Scotia in order to capture the complexities of these two collaborating professional groups working together individually. Intersectionality does not essentialize, and in the context of research about the care providers of women's reproductive health this is important as the traditional focus has been on an essentialized understanding of women (Hankivsky et al., 2010). Finally, intersectionality is important for working with people from a variety of backgrounds because it requires people to develop creative coalitions and alliances in order to address social justice issues (Hankivsky et al., 2010). With collaboration between midwives and nurses at the heart of this research, my hope is that the findings can be used to build coalitions and alliances of midwives and nurses to create innovative and collaboration models of practice, based on midwifery values, for maternal and newborn health in Nova Scotia, and in Canada.

### **3.4 Poststructuralism**

Poststructuralism has become a frequently used term to describe a paradigm for understanding the world (Cheek, 2000). Poststructuralism is often referenced alongside the term postmodernism, and the terms are often used interchangeably, due to the overlapping nature of each of the perspectives. This makes the articulation of a definition of poststructuralism difficult. Both poststructuralism and postmodernism challenge what we take for granted within our realities, they also present the notion that thoughts and experiences have plural meanings, rather

than one specific meaning (Cheek, 2000; Weedon, 1987). The focus on thoughts and experiences having plural meanings, has resulted in many interpretations of poststructuralist meanings and many contributors to poststructuralist theory.

Foucault and Derrida are two important contributors to poststructuralist theory (Weedon, 1987). While many scholars attribute poststructuralism to the work of Foucault, he insisted that his work not be categorized (Cheek, 2000). Foucault challenged notions about knowledge and the commonly held assumption that knowledge is objective and that knowledge is progressive (Cheek, 2000). In his work, Foucault explored the relationship between knowledge and power (Cheek, 2000), and how this relationship influences daily practices.

While it is difficult to differentiate between poststructuralism and postmodernism (Agger, 1991), authors have identified two main differences in each of the schools of thought. Poststructuralism has generally come to be associated with the study of knowledge and language, where postmodernism is understood to be associated with the study of culture (Agger, 1992). Loosely, this distinguishes poststructuralism from postmodernism, however the distinction is actually quite blurry and there is an overlap and a fluidity between these two understandings of poststructuralism and postmodernism (Agger, 1992). Poststructuralism and postmodernism both reject the goal of developing grand theories (Cheek, 2000; Cheek & Rudge, 1994).

Poststructuralism itself, is plural, in that it does not have one fixed meaning or definition (Cheek, 2000). There is also resistance to create a formal method or methodology for poststructuralism (Cheek, 2000) because a formal, singular methodological approach would remove the emphasis on plural meanings, methods, and contributions to poststructuralism. This means that there is no singular or formulaic approach to the use of poststructuralism and no way to measure how a researcher applies poststructuralism to their research. Instead, one must

develop an in-depth understanding of key poststructural writings and concepts as they relate to one's understandings of reality and the research being conducted.

### **3.4.1 Poststructural Concepts.**

It is crucial to understand the key concepts of poststructuralism in order to envision how it can be used in research. Given that poststructuralism acknowledges the plurality and multiplicity of meanings for words and concepts, I recognize that the discussion about poststructural concepts that follows can be contested. What I hope to illustrate in the next section is my understanding of poststructuralism, based on the literature I have read. In keeping with poststructural principles, this section reflects my current beliefs around poststructuralism. I will discuss the following concepts; power relations, discourse, text and language, governmentality, surveillance, subjectivity and subject positions.

#### ***3.4.1.1 Power Relations.***

Poststructuralism offers a useful approach to gain an understanding of power as both fluid and contextually specific. For Foucault, power is productive because of its relationship to knowledge and how it allows for certain types of knowledge to be known and other types of knowledge to be unknown (Cheek, 2000). For Foucault, power is understood within its context of 'relations of power' which exist everywhere (Foucault, 1982; Weedon, 1987). These power relations constantly change and there is no fixed power dynamic, instead the power relations are a fluid dynamic (Foucault, 1982; Weedon, 1987). The existence of power relations depend on action and therefore power becomes visible through its use (Foucault, 1982).

How power is exercised is dependent on three overlapping relationships; power relations, relationships of communication, and objective capacities (Foucault, 1982). Power relations refer to the relations of power between individuals and groups (Foucault, 1982). Relationships of

communication are responsible for sharing information which can be done through the use of signs, symbolism, or language (Foucault, 1982). Objective capacities involve how the use of one's body or the use of instruments can transmit power (Foucault, 1982). Together, these three relationships overlap with one another to both maintain and support an agenda of power which is contextually specific (Foucault, 1982). Power relations are deeply imbedded in social networks and the systems that govern them (Foucault, 1982).

Poststructuralism offers a way to understand the dynamics of power within historical, social, and institutional contexts (Cheek, 2000). It does not offer specific strategies to challenge or change power relations (Cheek, 2000). However, improved understandings of power relations, provide possibilities to enhance and improve collaboration, between inter-professional groups such as midwives and nurses.

#### ***3.4.1.2 Discourse.***

Poststructuralism attends to a multiplicity of discourses (Weedon, 1987). According to Cheek (2000), "...a discourse is a set of common assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge," (p.23). Discourses are often reflected in the ways that we speak and think (Cheek & Rudge, 1994; Mills, 2003). At the same time, discourses influence our understandings of reality (Cheek, 2000; Mills, 2003) and often co-create discursive frameworks which shape our experiences of reality (Cheek, 2000). Discourses can be used as mechanisms to oppress or resist depending on how relations of power are used (Mills, 2003).

Relations of power are also important for determining dominant discourses within a society or group. While many discourses exist at any time and in any place, they do not all exist with equal authority or representation (Cheek, 2000; Weedon, 1987). A dominant discourse is

the embodiment of power relations which determine what knowledge is known and produced (Cheek, 2000; Mills, 2003). An example of a dominant discourse in Canada would be that the hospital is the safest place to give birth. Most people assume that this is accurate and that to give birth elsewhere is dangerous. An alternative discourse purports home or birth centres as safe places for low-risk women to give birth. This discourse challenges the dominant discourse, and is often met with resistance by those who uphold the hospital as the safest location to birth. Evidence is used to support both discourses yet despite evidence which demonstrates the safety of home and birth centres for childbirth (Hutton et al., 2016), the discourse about hospitals as the safest place to birth remains dominant.

According to a poststructuralist approach, discourses, language, and the meanings produced through language are not fixed, but constantly change due to social, historical and institutional influences and power relations (Weedon, 1987). The result is that discourses are not static and have the potential to be challenged and changed. An exploration of the discourses surrounding midwifery and nursing in Nova Scotia illuminated power relations within the context of collaboration and helped to identify discourses in need of change.

#### ***3.4.1.3 Text and language.***

Language is always historically and socially situated (Weedon, 1987). Language is how knowledge (Agger, 1992; Cheek, 2000) and meanings of experiences (Weedon, 1987) are expressed. There are many languages and many meanings attributed to the words and phrases that we use, this illustrates that a singular universal meaning is difficult to assign to an aspect of language (Weedon, 1987). For example, the word midwife can have different meanings for different people. Some people understand midwives to be nurses who have undergone additional education in midwifery. Others see midwives as health care professionals who have successfully

completed a four year undergraduate degree in midwifery. There are still others who understand midwives to have been trained by senior women in the community to care for women during labour and delivery. All of these understandings are influenced by the context in which the language is used and the concept is experienced. Understanding that languages have many meanings, expressed in multiple modes of text, will be important for the collection and analysis of data for this proposed research.

Language is not objective, but rather the use of language is subjective to the person using it and the context in which it is being used (Cheek, 2000). It is both created by the reality in which it is used and it creates the reality in which it is used (Cheek, 2000). This is an example of a constructivist understanding of language. Poststructuralism is particularly concerned with questioning “language, meaning, and subjectivity” (Cheek, 2000, p. 42).

Text has many forms which can include; written works, conversations, and artwork (Cheek, 2000). Discourses are conveyed through language and language is expressed through text. In other words, the combination of knowledge and power relations create discourses which are conveyed through language, and language creates text. What is of particular interest in poststructural approaches is the identification of what knowledge is excluded from text (Agger, 1992). Through the exploration and examination of what is excluded from text, insights about the current use of discourses and the dynamics of power are often illuminated (Agger, 1992). Discourse analysis is one approach to understanding texts within their social, cultural, and historical contexts (Cheek, 2000).

#### ***3.4.1.4 Surveillance.***

The concept of surveillance was highlighted with Foucault’s description of the panopticon in *Discipline and Punish* (1975) and how that system of surveillance exemplified

how surveillance is embedded in the systems and structures of society (Cheek & Rudge, 1994). The way that the panopticon was arranged, with a guard at the centre and the prisoners in cells around the central guard post, both the prisoners and the guard never knew when they were being observed (Cheek & Rudge, 1994). The prisoners could be observed by the guard and by other prisoners, and the guards could be observed by the prison governor (Cheek & Rudge, 1994; Foucault, 1975). Due to the ongoing potential to be observed, the prisoners and the guards eventually conducted themselves according to the expectations of the prison, using self-discipline to adhere to the compliant behaviour as defined by the prison (Cheek & Rudge, 1994; Foucault, 1975).

Foucault used this example to argue that surveillance was used within societal and systemic structures to govern populations (Cheek & Rudge, 1994). For Foucault, knowledge is controlled – who has access to it, who creates it, etc... by designated experts within a society (Cheek & Rudge, 1994). Examples of sites where knowledge is controlled in this manner are hospitals and schools (Cheek & Rudge, 1994). In a hospital, nurses contribute to the surveillance of patients who are subjected to surveillance techniques such as observation and various assessment techniques. Further, the results of these surveillance activities are recorded and documented in patient records, which are often not accessible to the patient (Cheek & Rudge, 1994). Due the uncertainty of when these surveillance practices will take place, most patients regulate their own conduct and behaviour to the expectations of the hospital.

#### ***3.4.1.5 Governmentality.***

For Foucault, government is defined as how the conduct of individuals or groups could be directed (Foucault, 1982). Foucault (1982) defines the ability to govern as, “...to structure the possible field of action of others,” (p.790). In these understandings of government and the action

of governing, the concept is not limited to a state or political system (Foucault, 1982).

Governmentality relies on the combination of power relations, surveillance, and discipline for the development and maintenance of a structure that reinforces the need to ensure that normal conduct and behaviours are adhered to (Foucault, 1975). Those in positions to govern, are typically the ones who have power. According to Cheek (Cheek & Porter, 1997), those who are governed also have power through their ability to enact their agency to either submit to being governed or to resist being governed. With surveillance, the threat of discipline is used as a consequence for not adhering to expected norms of conduct and behaviour. Thus, surveillance is used by individuals and institutions to maintain governance over the conduct and behaviour of individuals.

An example of being governed in maternal newborn health care can be seen in discourses regarding the location where a woman chooses to give birth. A dominant discourse which upholds the value of hospital births, governs the thoughts, decisions, and actions of women and their families who choose to give birth in hospitals instead of at home or in birth centres. Childbirth in a hospital has behavioural and conduct expectations associated with it that are different from those associated with a home birth. In a hospital, there are often policies and guidelines that govern a woman's actions. Policies about eating during labour are common in hospitals, where at home a woman in labour is not restricted to a policy that governs if and what she can eat. At home, a labouring woman can eat whatever she wants and whenever she wants. In this example the institution (hospital) governs the activities of a labouring woman in ways that are different from a woman labouring at home.

### ***3.4.1.6 Subjectivity and subject positions.***

Foucault (1982) defines the subject as, "...subject to someone else by control and dependence; and tied to his own identity by a conscience or self-knowledge," (p.781). Both of these definitions reflect how power is involved in the subjugation or subjection of an individual (Foucault, 1982). Discourses are composed of different subject positions, and subjectivity occurs when individuals allow themselves to be regulated by a discourse (Weedon, 1987). The subject position is then influenced by how an individual allows themselves to be regulated by the discourse. In other words, an individual may choose between varying levels of regulation and this influences where they position themselves within the discourse.

Our subject position within discourses is important as it informs the ways that we view the world and it also informs how we make decisions to perpetuate or resist certain discourses (Weedon, 1987). The decisions to perpetuate or resist certain discourses influence how discourses become dominant within a society, because the ability of a discourse to become dominant relies on multiple individuals' willingness to be governed by it (Weedon, 1987). Thus, for this proposed research, understanding the subject positions of midwives and nurses and how they perpetuate or challenge dominant discourses will provide deeper understandings of how collaboration has been influenced.

The goal of a poststructural approach is to explore how knowledge and power is conveyed through language, in the form of texts. It is important to consider how texts reflect or illustrate power relations, specifically with regard to what is missing or left out, and therefore excluded from a discourse. The goal is not to replace one discourse with another, but to foster an understanding of a multiplicity of discourses and how power relations influence the way in which discourses have meaning.

### **3.4.2 Critiques of poststructuralism.**

One of the critiques of poststructuralism is that it results in political and ethical paralysis (Francis, 2000). This is a result of the ambiguities and uncertainties of unfixed meanings, multiple changing discourses, changing relations of power, and inability to provide generalizations (Francis, 2000). Poststructuralism acknowledges an ongoing process of changing power relations, discourses, language, and meanings which are continuously influenced by historical, social and institutional perspectives (Weedon, 1987). This approach is particularly useful for exploring experiences and understandings of collaboration, as collaboration has been defined as an ongoing process (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005).

Poststructuralism based on Foucault's work has been critiqued by feminists for its "gender blindness" (Sawicki, 1996). In this critique, feminists point to Foucault's work as deeply masculinized without mention of the role of gender (Sawicki, 1996), despite his focus on power relations and subject positions. As Sawicki (1996) points out, this is variously problematized by feminists, where some feminists view his exclusion of gender as a reason for the complete incompatibility of poststructuralism and feminism. Other feminists such as Judith Butler argue that poststructuralism offers useful tools that can be used to address the traditional feminist agenda of emancipation from patriarchy (Sawicki, 1996).

### **3.4.3 What does poststructuralism contribute to this research?**

There are three contributions that poststructuralism made to this study. First, poststructuralism provided a frame to attend to power relations and contextual discourses. That is, with the view that power relations are everywhere and have the potential to be productive, the binary concept of power as something that is consistently exerted over or upon an individual

group is challenged. This limited understanding of power was removed and this created an opportunity for analysis that accounted for complexities and fluid dynamics of power relations between individual midwives and nurses. Further, poststructuralism offered a reminder that discourses are context specific and they can be influenced by all manner of factors.

Understanding discourses that are influencing midwives and nurses assisted in the development of an in-depth understanding of how the two professional groups collaborate individually and collectively.

Secondly, poststructuralism provided a frame to assist with the identifications of alternate knowledge claims (Cheek & Porter, 1997) and to explore non-dominant discourses in their relationship to dominant discourses. The exploration of multiple discourses, social positions, and contexts that influence the daily practices of midwives and nurses contributed to our understandings about how their collaborative experiences were shaped by all of these influencing factors. Poststructuralism also provided a frame to understand what was excluded from competing discourses.

Finally, poststructuralism offered the potential of working with instead of against power (Cheek & Porter, 1997). Using Foucault's understanding of power as a productive concept (Cheek & Porter, 1997), not limited to an exercise of dominance, opened up the possibility for broader understandings of power relations between these two professional groups. It also offered a lens to see potential innovative power relations in the context of collaboration. These innovative approaches to collaborative power relations may have already been occurring between midwives and nurses, but were yet to have been articulated due to the social positioning of both professional groups. Poststructuralism provided an opportunity to explore such innovations as they relate to collaboration.

### 3.5 Feminist Poststructuralism

Feminist poststructuralism brings together feminist and poststructuralist perspectives in order to critique and transform dominant discourses and expressions of power relations. Weedon defines feminist poststructuralism as, "...a mode of knowledge production which uses poststructuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change," (1987, p. 40). Weedon's definition of feminist poststructuralism is important because it unites two complementary perspectives, each of which identify the need to understand the dynamics of power and to identify strategies for change, within the context of multiple discourses.

Weedon (1987) did not use a specific feminist theory when defining feminist poststructuralism. Although she never explicitly referred to intersectionality as a feminist theory that was congruent with poststructuralism, she implicitly referred to several characteristics present in intersectionality such as; an interest in understanding the dynamics of power, understanding that there are multiple experiences, contexts and realities, and an articulation of the need to transform many racial, class, and gender discourses (Weedon, 1987). It is not surprising that Weedon did not refer to intersectionality by name, as the term was first used in 1989 (Crenshaw, 1989) which was two years following the publication of her book about feminist poststructuralism. Interestingly, feminists have observed that there is a history of using intersectional perspectives without explicitly identifying them as intersectional (Carbin & Edenheim, 2013). It is therefore not outstanding that Weedon used intersectional ideas, considering that intersectionality originated with Black feminist theory (Crenshaw, 1989; hooks, 1984; Lorde, 1984) which predates the initial use of the term.

Intersectionality and poststructuralism both provide an understanding of power as a dynamic process and both accept that identities are not static, but are constantly changing (Davis, 2008). Feminism generally, insists on the need to change power relations (Weedon, 1987), specifically with regard to patriarchy and women's experiences and needs. Poststructuralism offers ways to understand power relations and possible ways that dominant discourses can be challenged (Weedon, 1987). Poststructuralism also recognizes that historical, social, and institutional contexts influence dominant discourses and our understandings of experiences within the world. This aligns with intersectionality's space for difference and emphasis on the inclusion of multiple intersecting categories (Carbin & Edenheim, 2013) and social positions (Collins & Bilge, 2016).

Using a feminist approach with poststructuralism attended to the role that gender has had in power relations and how dominant discourses have been shaped through language. A deeper understanding of the various discourses surrounding midwifery and nursing, and the relations of power between these professions from a poststructuralist and feminist perspective, has the potential to inform ways to build and sustain strong, collaborative maternity practices, improving maternity care for women and their families in Nova Scotia.

A feminist poststructuralist philosophical perspective guided this study to address the research question and issues outlined at the beginning of this paper. For this research, poststructuralism provided a perspective of how power was conveyed through language and how historical, social, and institutional discourses maintain or challenge power. Intersectionality provided a gendered perspective of the multiple intersecting contexts that may be influencing power relations between midwives and nurses and their experiences. Together, feminist

poststructuralism helped to illuminate how various discourses have influenced the meanings of collaboration for each of the study participants.

FPS provided an approach to explore and understand how historical, social, institutional, and gender discourses have influenced current power relations between midwives and nurses. FPS was an appropriate approach to use to understand how various discourses, including medical and midwifery discourses, influenced collaboration between nurses and midwives, because of its critical nature which offered insights to challenge existing dominant discourses (Weedon, 1987).

For this study, intersectionality provided a feminist perspective that was inclusive of the intersections of different contexts and social positions. Intersectionality is complimentary to poststructuralism which recognizes a multiplicity of contexts; social, historical and institutional, that influence how discourses have meaning and power (Weedon, 1987). Feminist poststructuralism provided an approach that guided the conduct of this research with the principle of inclusivity and an awareness of the nuances of power relations as they relate to collaboration between midwives and nurses.

## **Chapter 4: Research Methodology**

The design of the study was guided by Stake's constructivist approach to case study. Data collection and data analysis methods were also informed by feminist poststructuralist approaches and philosophies. This study is one of only a few (Anthony, 2011; Gallant, 2008; Keddy, 2006) which explicitly combines case study design and feminist poststructuralism (as described in chapter 3. To begin I will broadly discuss qualitative research and then focus on case study. This will be followed by a description of the study setting, recruitment and sampling. Next, I will describe the data collection methods including; interviews, document review, and field notes. In the data analysis section I will describe how I conducted the discourse analysis. Finally, I will address the issues of trustworthiness of the data, ethical considerations, and plans for dissemination.

### **4.1 Qualitative Research Designs**

Qualitative research designs are often employed by researchers who aim to understand their research topic from an experiential, relational, and holistic perspective, and within their natural contexts. Studies that employ qualitative designs are reflective of the values present in critical theory and constructivist paradigms, discussed in chapter 2. Philosophically, researchers who employ qualitative designs for their research share similar paradigmatic stances.

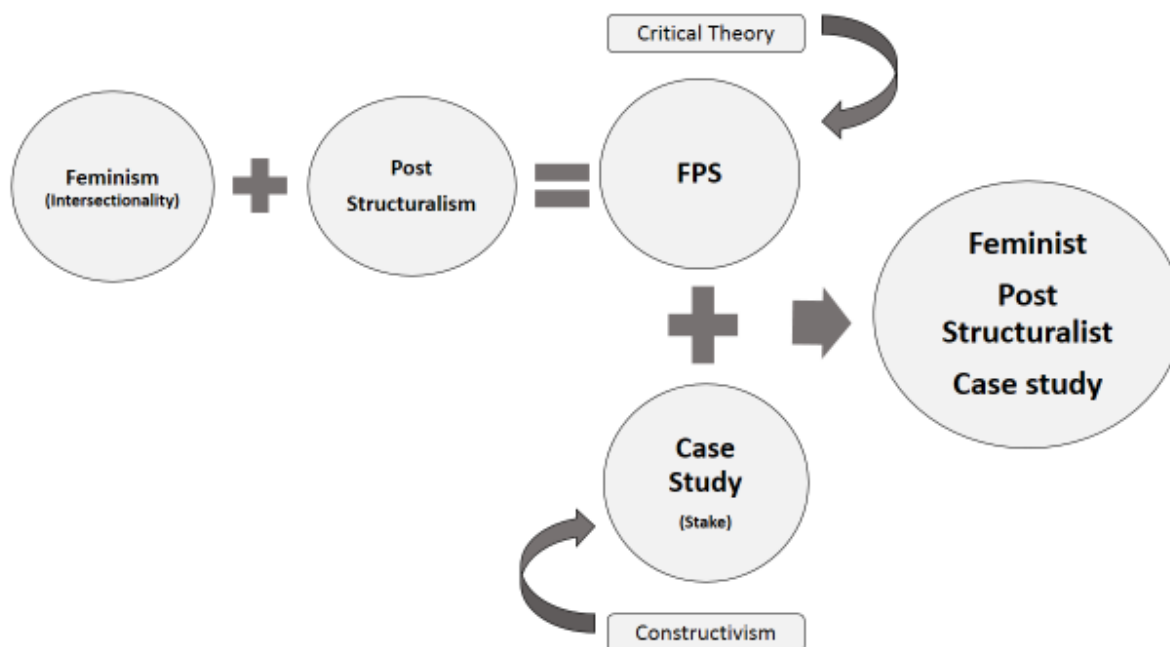
According to Creswell and Poth (2018), there are four philosophical assumptions that unite the various qualitative designs that researchers can employ for their studies. The first of these assumptions relates to ontology, that is, what we know about reality. Researchers using qualitative designs recognize the multiplicity of realities and the ability for these realities to be experienced and perceived in multiple and various ways (2018). The second assumption relates to epistemology, that is, how we know what we know. For researchers using qualitative designs,

subjectivity is valued, such that the participants' experiences, relationships, ideas, and beliefs are the evidence for the research (2018). The third assumption relates to axiology, that is, how values influence our knowledge. With this assumption, researchers using qualitative designs recognize that all research is value-laden and reflective of personal biases (2018). The final assumption that unites the use of qualitative designs with methodology, that is, how research is conducted.

Researchers using qualitative designs, employ an inductive approach to research, they do not aim to make grand generalizations, and they conduct their research within the context in which the topic or phenomena occurs (2018).

Stake's (1995) approach to case study research provided a constructivist design for this research. Feminist poststructuralism (Collins & Bilge, 2016; Weedon, 1987) provided a critical perspective with regard to the exploration of context, gender, and power within the case ( See Figure 1).

Figure 1 Methodological Approach



Feminist poststructuralism and case study are both epistemologically positioned to recognize the existence of multiple realities and multiple experiences of those realities. Case study and feminist poststructuralism studies value subjectivity and both rely on the experiences, relationships, ideas, and beliefs for evidence. Feminist poststructuralism and Stake's (1995) case study design recognize and accept the presence of researcher bias in research studies. The researcher must be accountable to their perspective and values through an explicit description of both. Finally, feminist poststructuralism and case study are both aligned with Creswell and Poth's (2018) description of qualitative methodology as they both employ an inductive approach to research, neither aim to produce grand generalizations, and the context of the topic or phenomenon of study is of central importance.

## **4.2 Case Study**

Case study has emerged out of a constructivist paradigm (Baxter & Jack, 2008; Gerring, 2004; Sandelowski, 2011; Welch, Piekkari, Plakoyiannaki, & Paavilainen-Mäntymäki, 2011), recognizing that multiple socially constructed realities exist (Baxter & Jack, 2008). Historically, case study has been used by many disciplines including anthropology, education, and medicine (Creswell, 2013; Flyvberg, 2011; Yin, 2009). Despite its wide appeal and use, case study continues to be held in low regard (Flyvberg, 2011; Gerring, 2004; Yin, 2009), likely because case studies are poorly understood in terms of their definition and purpose, which may be a result of their wide use in many disciplines (Flyvberg, 2011; Gerring, 2004; Sandelowski, 2011).

Case study allows researchers to specifically focus on the context of a case (Baxter & Jack, 2008; Stake, 1995; Welch et al., 2011). In focusing on the context of the case, the aim of case study is not to produce generalizable findings (Stake, 1995). Instead, researchers using case study to focus on what Stake refers to as "particularization" (1995, p. 8). Stake (1995) describes

particularization as the exploration and examination of a particular case so that the researcher develops a deep understanding of that particular case.

Developing an in-depth understanding of a case has been identified as one of the main aims of a case study (Baxter & Jack, 2008; Gerring, 2004; Stake, 1995; Welch et al., 2011). The focus on the context of the case assists in the development of a deep understanding of the phenomena being studied. Case studies provide the framework for researchers who seek answers to ‘how’ and ‘why’ questions (Baxter & Jack, 2008; Stake, 1995; Yin, 2009). These types of questions tend to yield findings that inform a deeper understanding of the topic of interest. The subjects that case studies explore are often phenomena about which very little is known (Gerring, 2004). The main research question for this feminist poststructuralist case study is a ‘how’ question and therefore aligns with case study design.

Case studies are interpretive, the researcher collects data and interprets the meaning of the data through analysis (Stake, 1995; Welch et al., 2011). The use of interpretation throughout analysis contributes to an in-depth understanding of the topic of interest. While there are often formal periods of focused analysis, in case study, analysis is ongoing throughout the data collection process to ensure that the research topic of interest is attended to and relevant data is collected (Stake, 1995).

There are many approaches to the conduct of case study research, however two of the most recognized approaches have been developed by Robert Stake (1995) and Robert Yin (2009). Yin provides a post-positivist approach to case study, while Stake provides a more constructivist approach to case study. Yin’s post-positivist approach to case study is most apparent in the influence of experimental research on the case study methodology he describes, specifically regarding; his concern with bias (Yin, 2009), description of replication as a means to

ensure trustworthiness (Bergen & While, 2000), and his pronouncement that case study is not limited to qualitative research (Yin, 2009). Stake's constructivist approach is apparent in his understanding of case study as a research approach and not a research methodology and his focus on case study as a means to conduct exploratory research (1995). Given my paradigmatic location within constructivist and critical theory, and given how this has influenced my interest in exploring collaboration between midwives and nurses in Nova Scotia, I used Stake's approach for this research.

#### **4.2.1 Case study features**

A key feature in defining case study as a research design is the "binding" (Stake, 1995) or "casing" (Ragin, 1992) of a case. Essentially, both of these terms refer to the creation of a boundary around the case (Baxter & Jack, 2008; Gerring, 2004; Sandelowski, 2011; Stake, 1995). Examples of boundaries used to define a case could include; geography, time, or activity (Baxter & Jack, 2008; Gerring, 2004; Sandelowski, 2011; Stake, 1995). These boundaries act as inclusion criteria for a case study and help to ensure that the researcher clearly articulates and stays within the scope of their study (Baxter & Jack, 2008). It is also important to note that the boundaries of a case are flexible, such that the "binding" or "casing" of the case can be ongoing through the study itself (Ragin, 1992; Sandelowski, 2011; Stake, 1995).

Another important feature of case study, according to Stake, is the use of "issues" (1995, p. 16) to ensure that the researcher attends to the contextuality and complexity of the case. These issues are linked to the multiple contexts that may influence the findings such as; social, historical, political and personal contexts (Stake, 1995). Issues can be framed as questions and ensure that the conduct of the case study is organized (Stake, 1995). Like the boundary of a case study, the issues also ensure that the researcher remains organized and focused on the case.

Case study is flexible in its approach (Sandelowski, 2011; Stake, 1995). For Stake (1995), this flexibility can be applied to the research question, data collection, and data analysis. The idea is that if one is exploring a relatively new phenomenon, then their approach must be adaptable to the knowledge they gain as they conduct the study. This is one strength of using a case study design.

#### **4.2.2 Types of case studies**

Stake outlines three types of case studies within his approach to case study research design. The types of case studies are defined by how the cases are identified and whether they have been created or already exist (Stake, 1995). The three types of case studies, according to Stake are; intrinsic case study, collective case study, and instrumental case study (Stake, 1995). Stake (1995) describes an intrinsic case study as a study in which the case is an obvious object of study. Researchers using intrinsic case studies are not driven by a larger question about how a phenomenon works or occurs, they are very focused on providing an understanding of the specific case in and of itself (Stake, 1995). According to Stake (1995), a collective case study embraces the idea that the case is used to understand something beyond the specific case being studied. This is similar to the instrumental case study, however in a collective case study, several instrumental case studies are studied together (Stake, 1995).

I used an instrumental case study design for this research. Stake (1995) describes an instrumental case study as constructed by the researcher in order to understand something other than the case itself (Stake, 1995). The aim of an instrumental case study is to conduct research about a specific case which can assist in developing a general understanding about a specific topic or phenomenon (Stake, 1995). In other words, a researcher focuses on developing an in-depth understanding of a specific case in order to improve one's understanding of the topic or

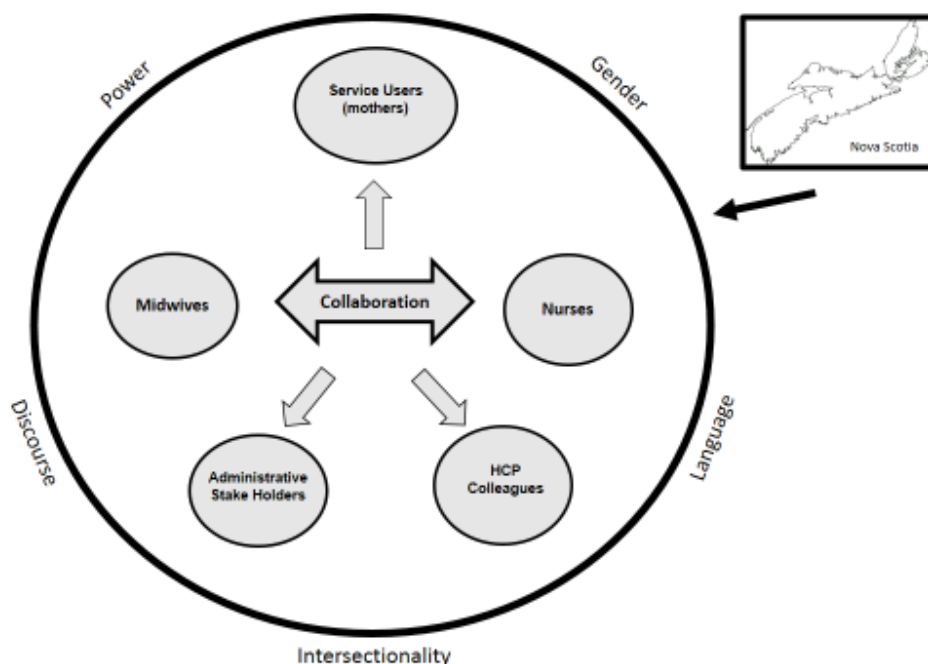
phenomenon beyond the specific case (Stake, 1995). This type of case study is appropriate because I was interested in understanding how midwives and nurses collaborate. An in-depth study of how midwives and nurses collaborate in Nova Scotia will contribute to our understanding of collaboration between midwives and nurses in Canada. The findings of this case study are not be generalizable, however they augment our knowledge about collaboration between midwives and nurses.

#### **4.2.3 Feminist poststructuralist case study**

Stake (1995) described the use of a conceptual framework, although he did not provide an example of one in his book. Baxter and Jack (2008) also described a conceptual framework that Baxter created for a case study. Baxter and Jack (2008) suggested that the framework should include the boundaries of the study and assist during the interpretation phase of the case study. A conceptual framework should continue to change throughout the course of the study (2008).

As illustrated (see Figure 2), for this case study, I created a conceptualisation of the case for the purpose of providing visual clarity with regards to the phenomenon of interest (collaboration between midwives and nurses) at the centre, and linked by arrows to the study participants or sources of information (midwives, nurses, service users, administrative stakeholders, other health care providers). The theoretical concepts from feminist poststructuralism (gender, discourse, intersectionality, language, power) are shown around the case, and the geographical boundaries of the case (Nova Scotia) are illustrated.

Figure 2 Conceptualisation of the Case



This conceptualisation of the case served as a visual reference of the important elements of the study and provided a visual map throughout the research process. In Figure 2, the boundaries of the case and important feminist poststructuralist concepts were clearly identified. The geographical boundary of this case study was the province of Nova Scotia, which allowed for the inclusion of the three locations where midwifery services are currently available. The time boundary was the previous 2 years before receipt of ethical approvals. Midwives, nurses, and health care provider colleagues had to have worked within the past two years and had to be currently practicing at the time of the interview. Service users had to have received care from a Registered Nurse and Registered midwife during the perinatal period within the last two years. The phenomenon to be explored was collaboration between midwives and nurses. Feminist poststructuralist concepts, as described in chapter 3 guided data collection and data analysis.

As discussed previously, Stake (1995) was clear about the need to identify issues, informed by the research question, for a case study. I developed six issues, informed by the research question, how do midwives and nurses collaborate in Nova Scotia? The following six issues (previously described) guided this feminist poststructuralist case study; a) What is the meaning of collaboration, during the provision of perinatal care, for nurses and midwives? b) How do midwives collaborate with nurses during the provision of perinatal health care? c) How do nurses collaborate with midwives during the provision of perinatal health care? d) What are service users' (mothers) perspectives of collaboration between midwives and nurses during perinatal health care? e) What are administrative stakeholders' (managers, decision makers, etc..) and health care provider colleagues' (physicians, obstetricians, doulas) perspectives of collaboration between midwives and nurses? f) How do social, historical, and institutional discourses influence collaboration between midwives and nurses in Nova Scotia? The final issue (f) was woven throughout the data collection and analysis processes for the entire study. These issues were reflective of my feminist poststructuralist philosophical perspective and were attended to throughout the data collection and data analysis stages of this study.

### **4.3 Study Setting**

This study was conducted in the province of Nova Scotia, Canada, which is a province located on the east coast of Canada, near the Atlantic Ocean (see Appendix C). In 2017, Nova Scotia had an estimated population of 953,869 (Statistics Canada, 2017) and has a land mass of 53,338 km<sup>2</sup> (Government of Canada, 2016). Nova Scotia currently has one Health Authority, the Nova Scotia Health Authority under which all hospitals are governed (Province of Nova Scotia, 2015). The IWK Health Centre, a tertiary centre for maternal-newborn and child health for the

Atlantic region and families in the Halifax Regional Municipality, partners with the Nova Scotia Health Authority, but is not governed by it (Province of Nova Scotia, 2015).

Between 2016-2017 there were 8467 births in Nova Scotia (Canadian Midwives Association, 2018). In the same time period, midwives attended 250 births, or 2.9% of births in Nova Scotia (Canadian Midwives Association, 2018). There is one tertiary level hospital, the IWK Health Centre, for maternal-newborn and child health in the province and it is located in Halifax, the capital city of Nova Scotia. Women, newborns, and children requiring emergent tertiary level or specialized care travel to the IWK Health Centre.

Midwifery is regulated throughout the province, however midwifery services are currently available at only three locations; Antigonish, Bridgewater, and Halifax. These three locations had health districts which were chosen to be model midwifery sites when midwifery was regulated in Nova Scotia in 2009 (Kaufman et al., 2011). Antigonish and Bridgewater are both towns in rural areas of the province, Halifax is the urban centre for Nova Scotia. Midwifery services have not yet been integrated into maternal-newborn health care services at other locations in the province.

There were nine midwifery positions in Nova Scotia, five at the IWK Community Midwives practice in Halifax and two each at the midwifery practices in Antigonish and Bridgewater. Midwifery services were suspended in January 2018 at the Bridgewater site (Mulligan, 2018; Rankin, 2018), leaving seven midwives practicing during the course of data collection for this study. All three locations offered hospital births and home births. With the suspension of midwifery services in Bridgewater, and only a handful of home births occurring at the Antigonish site, home births were only consistently offered by the midwives in Halifax during the time of data collection. In 2017, there were 18 home births attended by IWK

Community Midwives (K.Chisholm, personal communication, September 25, 2018). Registered nurses have been trained and have worked as second attendants for home births at all three sites, however at the time of data collection RN Second Attendants were only attending home births with the IWK Community Midwives. In 2017, RN Second Attendants supported and attended 13 of the 18 home births (K.Chisholm, personal communication, September 25, 2018). Midwives and nurses worked together during hospital births at the affiliated hospital sites in Antigonish and Halifax during the time of data collection, and in Bridgewater prior to the suspension of midwifery services in January 2018.

The setting of this study reflected the boundaries of this case, which were geographic, namely the province of Nova Scotia and the three specific locations in Nova Scotia where midwives are practicing. Having the geographic boundary coincide with the provincial boundaries allowed for flexibility to include any additional locations, had midwifery been integrated elsewhere, during the study. It also allowed for flexibility in participant recruitment, as there have been instances where women and their families have traveled from areas with no midwifery services to locations where midwifery services are available in order to give birth. Administrative stakeholders may have also been located outside of these three areas. One case, defined by a provincial geographic boundary, ensured the inclusion of participants from a variety of local contexts who may have had significant insight into collaboration between midwives and nurses in Nova Scotia. The three model sites where midwifery services were offered served as entry points for recruitment and data collection.

#### **4.3.1 Ethical Concerns**

Ethics approvals were obtained from the Research Ethics Board (REB) of the University of Ottawa, the IWK Health Centre, and the Nova Scotia Health Authority (see Appendix D). The

study strictly adhered to the protocol approved by these REBs. All consent forms were reviewed and discussed with participants, with time provided for questions, prior to obtaining participant signatures. I took the following measures to maintain confidentiality of the participants; (a) Participants were informed that they would have an alias or pseudonym used to identify their transcript (Participants chose their own pseudonyms). The list of participant names was kept separate from the data collected. A non-identifiable code was assigned to each participant who completed the demographic profile; all identifying information was kept confidential. Only I had access to codes that could be linked to participant identities. Contact information of participants was stored separately from any research data, (b) Interviews were conducted in private locations, (c) During data collection and analysis, only I had access to the raw data (transcripts and audiotapes), which was kept in a locked brief case, locked filing cabinet, or on a password protected personal computer. Files were password protected. All raw data (audio recordings and transcripts) will be stored in a locked cabinet in thesis supervisor's office at the University of Ottawa, School of Nursing for five years following completion of the thesis, (d) The transcriptionist who had access to the audiotapes signed a confidentiality agreement, (e) Information sent to the transcriptionist was encrypted and password protected. Transcribed interviews sent back to me for analysis were encrypted and password protected, (f) Upon completion of the thesis, all raw data (transcripts and audiotapes) will be secured in a locked cupboard in the thesis supervisor's office at the University of Ottawa, (g) The information provided by participants was used only for the purpose of the study. During data collection, analysis, and thesis writing, data was kept in a locked cabinet or locked briefcase. The computer was password protected and all digital files were password protected. Only I was aware of the participants' identity and I confirmed their participation during the recruitment and screening process, and during group discussions.

I informed all participants that their anonymity was not guaranteed as I conducted the interviews myself. All participants were informed of their ability to withdraw from the study any time up until analysis began, with no adverse repercussion to their health care or work position. I provided information (a list of local mental health resources) to re-direct all participants to psychological support in the event that they were in need of those resources.

Participants were informed that confidentiality and anonymity could not be guaranteed in a group discussion setting. Participants were encouraged to decide how much they wanted to disclose about any topic. All participants were asked to sign an agreement to keep confidentiality with the consent process. All participants were reminded not to discuss the contents of the group discussion outside of the group discussion.

#### **4.4 Sampling and Recruitment**

There was one case for this proposed research about collaboration between midwives and nurses in Nova Scotia. The purpose of case study was not to generalize but to particularize (Stake, 1995). Therefore, the sample size was not chosen for representativeness, but rather to include a variety of perspectives to develop an in-depth understanding of this particular case. The study participants included; Registered Midwives, Registered Nurses, mothers, administrative stakeholders (managers, decision makers), and health care provider colleagues (doulas, physicians, etc...). I was purposeful in recruiting participants from each of these groups that met the inclusion criteria (See Table 1)

Table 1: Inclusion Criteria for Study Participants

|                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Registered Midwives             | <ul style="list-style-type: none"> <li>-currently practicing at one of three midwifery model sites in Nova Scotia</li> <li>-practiced in Nova Scotia within the last 2 years</li> <li>-currently registered with the Midwifery Council of Nova Scotia</li> </ul>                                                                                                                                                                           |
| Registered Nurses               | <ul style="list-style-type: none"> <li>- currently practicing perinatal care (labour and delivery, postpartum, or at home births as a home birth attendant) at one of the three model sites where midwifery services are offered in Nova Scotia.</li> <li>-practiced at one of three midwifery practices in Nova Scotia within last 2 years</li> <li>-currently registered with the College of Registered Nurses of Nova Scotia</li> </ul> |
| Mothers                         | <ul style="list-style-type: none"> <li>-mothers who have received care from both a Registered Nurse and a Registered Midwife during labour/delivery/24 hours postpartum at home or in the hospital in Nova Scotia within the last 2 years</li> </ul>                                                                                                                                                                                       |
| Administrative stakeholders     | <ul style="list-style-type: none"> <li>-leaders with a vested interest in the collaboration between midwives and nurses in Nova Scotia</li> <li>-leadership role any time since midwifery was regulated in Nova Scotia (2009).</li> <li>-this may include (but is not limited to); team leaders, managers, policy creators, decision makers</li> </ul>                                                                                     |
| Health care provider colleagues | <ul style="list-style-type: none"> <li>-currently practicing at one of the three model sites offering midwifery services in Nova Scotia</li> <li>-practiced in Nova Scotia within last 2 years where midwifery services are offered</li> <li>- currently registered with regulatory body or association of their profession</li> </ul>                                                                                                     |

All participants were able to read and write English fluently and they were over 18 years of age. This lower age limit ensured that participants were consenting adults. Participants in the study were encouraged to suggest that their colleagues and peers participate in the study. Enrollment into the study was done on a first come/first served basis.

For interviews, the anticipated sample size was 23-25 participants (See Table 2). The anticipated sample size reflected an attempt to provide equal opportunities for the voices of participants to be heard. This was important from a feminist perspective as an attempt to provide equitable opportunities for participation in research from groups that are often voiceless or marginalized (Ardovini, 2015). The service users, administrative stake holders, and health care provider colleagues (doulas, physicians, etc..) were fewer in individual numbers, in comparison

to the numbers of midwife and nurse participants, as their experiences and perspectives provided the context for the case.

Table 2 Anticipated Sample Size

| <b>Participant Group</b>        | <b>Anticipated Number of Participants</b> |
|---------------------------------|-------------------------------------------|
| Midwives                        | 7                                         |
| Nurses                          | 7                                         |
| Mothers                         | 3-4                                       |
| Administrative stakeholders     | 3-4                                       |
| Health care provider colleagues | 3                                         |
| <b>Total:</b>                   | <b>23-25</b>                              |

Individual and group interviews were conducted with a total of 4 participants who provided feedback about the preliminary findings.

#### **4.4.1 Recruitment.**

I used purposeful and snowball sampling to recruit participants. Purposeful sampling is when a researcher seeks participants that can provide information about the topic of interest (Creswell & Poth, 2018). I purposefully recruited participants who could share their experiences and perspectives of collaboration between midwives and nurses in Nova Scotia. Snowball sampling is when participants are referred by people who have already participated in the study, often through word of mouth (Creswell & Poth, 2018; Polit & Beck, 2012). Participants shared study information with other potential participants. Recruitment for participant interviews for this study was ongoing for six months.

One of the most important aspects of recruitment was the ability to gain access to the potential participants of the study (Creswell & Poth, 2018; Stake, 1995). I emailed key gatekeepers at the three models sites where midwifery services were offered to share information and seek their support for the study. These gatekeepers were comprised of the managers of midwifery and of nursing (for the maternal-child units, birth unit, and postpartum unit). I also

emailed representatives of the Association of Nova Scotia Midwives and the Midwifery Coalition of Nova Scotia to share information of the study and seek their support.

Participants were recruited from the following organizations; IWK Health Centre, Halifax, Nova Scotia, St. Martha's Regional Hospital, Antigonish, Nova Scotia, South Shore Regional Hospital, Bridgewater, Nova Scotia Midwifery Coalition of Nova Scotia (Provincial Consumer Group), Nova Scotia, and the Association of Nova Scotia Midwives (Provincial Association), Lunenburg, Nova Scotia. I sent letters of information (see Appendix E) and posters (see Appendix F) to the managers of each of the units. At the managers' discretion, posters were placed at the nurses' stations and break rooms on the units. The managers of each of the units also forwarded letters of information about the study and the poster via internal email to nurses on their units, and the midwives practicing in the midwifery programs. Study information was shared on a postpartum unit during team huddles, where nurses met prior to their shift in order to share important clinical and institutional information. I made a point to visit each of the model sites shortly after recruitment began in order to meet managers and team leaders I had not met and to ensure that study posters were posted in visible places. These visits also informed my understanding of the institutional environments in which midwives and nurses collaborate in Nova Scotia.

I emailed the letter of information for midwives (see Appendix E) and study poster to the Association of Nova Scotia Midwives. This study information was distributed by an Association representative via email to members. Study information was also shared at Association meetings, where midwives were encouraged to participate.

Recruitment for mothers involved multiple strategies. For example, midwives at one midwifery practice placed a poster at their reception desk for potential mother participants to

view. Midwives at another midwifery practice shared letters of information (See Appendix E) with potential mother participants. I also posted the study posters on the Midwifery Coalition of Nova Scotia (a consumer group) Facebook group.

Key administrative stakeholders and health care provider colleagues were purposefully identified and invited to participate, with letters of information (see Appendix G) via email. Participants were all encouraged to share information about the study with colleagues and people they thought might have been interested in participating. Posters and study information letters were made available to participants who were interested in sharing study information.

Midwife and nurse participants who had indicated their interest in participating in a focus group (see Appendix H) during the interview process were contacted to attend a group discussion. Midwives were contacted through a representative of the Association of Nova Scotia Midwives, and a time of mutual convenience was set for the midwife group discussion. Nurse participants were contacted individually, per their indicated interest to participate in a focus group. Due to schedule conflicts and geographical distance between participants, nurses participated in individual telephone interviews.

Challenges of recruitment included; the suspension of midwifery services at the Bridgewater site one month prior to the beginning of recruitment, initiating and sustaining recruitment at three sites that were not in close proximity, accommodating shift work and on-call schedules. The suspension of midwifery services at one of the sites reduced the number of midwives that were currently practicing at the time of recruitment and data collection. This made it challenging to ensure that they received adequate notice of the study. The three physical sites where participants were recruited, were not located close together and it was challenging to have a meaningful physical presence that could have supported recruitment. Finally, it was

challenging to accommodate the variations in participants' schedules based on the demands of shift work and on-call work.

## **4.5 Data Collection**

There are a variety of data collection methods that are employed by researchers who conduct qualitative research studies (Creswell & Poth, 2018). Researchers using case study often use several data collection methods. These methods include; interviews, document review, and observation (Stake, 1995). Following ethical approvals, I used the following data collection methods for this research; interviews, document review, and field notes (these included observations from interviews). I conducted all of the data collection for this study.

### **4.5.1 Interviews**

The primary source of data were 17 individual interviews. Prior to commencement of the interviews, participants provided verbal and written informed consent. Participants were informed that their participation in the study was voluntary, and that they could withdraw from the study at any time up until analysis began. Participants were encouraged to ask questions and informed that they could stop or take a break at any time during the interview. Following this conversation of consent, we signed consent forms (Appendix I) and the participant was provided with a copy of the signed consent form.

Participants completed a demographic profile prior to commencement of the interviews (see Appendix J). In-depth individual interviews were conducted in quiet and private locations of the participants' choice (Creswell & Poth, 2018). The interviews were 30-90 minutes in duration. The interviews were guided by semi-structured interview guides (see Appendix K) which were informed by the research question, case study issues, literature, and feminist poststructuralist concepts. The semi-structured interview guides provided flexibility for me, as the interviewer, to

adapt to the responses of the participant while ensuring that the interview maintained focus on the overall research question and issues (Polit & Beck, 2012). The interviews were audio-recorded and were transcribed verbatim by a transcriptionist (Polit & Beck, 2012). The transcriptionist signed a confidentiality agreement prior to the commencement of transcription. The audio-recording and transcripts were encrypted and password protected (Creswell, 2013). I reviewed and compared the transcripts with the audio recordings to ensure transcription accuracy (Polit & Beck, 2012).

According to Polit and Beck (2012), saturation occurs during qualitative data collection when the data being collected are no longer new or different from that data that has already been collected. In this understanding of data collection, the researcher is constantly comparing the data already collected with the data being collected in order to ensure that a wide variety of data is collected. This data saturation approach is not congruent with a feminist poststructural perspective.

In this study I used a more individualized concept of data saturation, where saturation was achieved when the individual exhausted what they wished to share (O. Griscti, personal communication, July 11, 2016). In this approach, data saturation did not drive the data collection because feminist poststructuralism is concerned with not only what is being said, but also with what is not being said. This was important during the analysis stage, as the interviews were initially analyzed individually. The individual analyses were aggregated according to similarities of important issues raised by participants (M.Aston, personal communication, July 11, 2016). This was demonstrative of the participants' beliefs, values, practices, and discourses that influenced collaboration between midwives and nurses.

#### **4.5.2 Document review.**

Document review was a secondary data collection strategy that I used (Stake, 1995). The purpose of the document review was to provide further context to the overall case. The document review included the identification of relevant points related to collaboration between midwives and nurses, what was absent about collaboration between midwives and nurses, and the discourses influencing the document (see Appendix L). I reviewed 24 documents, including; one institutional policy, and one institutional report, and a variety of 22 media reports. Document review, was an iterative process, and decisions based on the number and types of documents to review were guided by data collected from participant interviews, accessibility to documents, and changes to midwifery service delivery in the province at the time of data collection.

Documents were primarily news articles published between January 2018, when the South Shore Midwifery services were suspended, and the end of August 2018, after midwifery services had resumed at that site. The media reports mostly related to the suspension of midwifery services at one of the model sites. I asked for policies and documents at all model sites, however, the province was in the midst of amalgamating multiple health authorities into one health authority and gate keepers/participants were reluctant to share previous policies as all policies were being used to create new singular policies to be used across the new health authority. Only three documents reported or mentioned collaboration between midwives and nurses; one was the institutional report about Registered Nurses as Second Attendants, one was a policy about how midwives and nurses should collaborate at home births, and one was a media report that mentioned that midwives and nurses worked together. The general absence of collaboration between midwives and nurses in the documents illustrated invisibility.

Data generated from the document review provided further information regarding the context in which collaboration between midwives and nurses occurred. The documents helped to uncover discourses present in the media (social and historical) and in institutions (policy, report). Discourses identified in the document review were also used to provide a broader context of the case at the time of data collection (see Table 3).

Table 3: Identified Discourses in Document Review

|    | <b>Discourses</b>                                                   |
|----|---------------------------------------------------------------------|
| 11 | More midwives are needed in NS                                      |
| 10 | Inequitable access to midwifery services in NS                      |
| 9  | Current midwifery program is not sustainable in NS                  |
| 4  | Midwifery needs to be properly resourced                            |
| 4  | NSHA is addressing the need of more midwives                        |
| 2  | Collaboration                                                       |
| 1  | Midwife as primary health care provider                             |
| 1  | No political will/commitment to invest in/expand midwifery services |
| 1  | Women's health care is not a priority                               |
| 1  | Midwifery can accommodate marginalized women and families           |
| 1  | No money to support midwifery program                               |
| 1  | Collapse of program is not surprising                               |
| 1  | Continuity of care with midwives                                    |
| 1  | Suspension of midwifery program means a loss of services            |
| 1  | Women need to fight for health care and midwifery services in NS    |
| 1  | Midwifery is continuity of care                                     |
| 1  | Midwives are burning out                                            |
| 1  | Midwifery is holistic care                                          |
| 1  | It doesn't matter who 'catches' a woman's baby in NS                |
| 1  | Midwifery program crisis in NS                                      |
| 1  | Home birth is safe                                                  |
| 1  | A woman has a right to choice of provider and place for her birth   |

This data was integrated inductively into the analysis of the interview data, and was used as a way to identify social and institutional discourses, and what was or was not visible socially. This reflected the flexible approach to case study research. Decisions regarding document review were made in consultation with my supervisor.

#### **4.5.3 Field Notes.**

As another secondary data source, I maintained field notes throughout the study. Field notes are a common data collection strategy in qualitative research (Creswell & Poth, 2018; Stake, 1995). The field notes provided a space where I recorded observations of participants during interviews, my thoughts and concerns throughout the study, and a documentation of study related activities. Overall, the aim of using field notes was to collect contextual data that assisted with developing an in-depth understanding of collaboration between midwives and nurses. The field notes were also used to document decision-making, challenges, and methodological issues throughout data collection process (Stake, 1995). This data source remained with me or in a locked cabinet when it was not in use. The field notes served as both a data source, audit trail, and place to engage in reflexivity.

#### **4.5.4 Individual and Group Discussions.**

One group discussion was conducted with the aim of providing an opportunity for midwives to share their feedback and responses to preliminary study findings. The group discussion was conducted separately in quiet and private locations of the participants' choice (Creswell & Poth, 2018). Two midwives participated in the midwife group discussion, which lasted 45 minutes in duration. Due to scheduling conflicts and distance between model sites, 2 nurses participated in individual telephone interviews where they shared their feedback and responses to preliminary study findings. The telephone interviews lasted 30-40 minutes in duration. The group discussions and telephone interviews were guided by a semi-structured interview guide (see Appendix M) which was informed by the research question and case study issues.

Prior to commencement of the interviews and group discussions, all participants provided verbal and written informed consent (see Appendix I and Appendix N). Participants were informed that their participation in the study was voluntary, and that they could withdraw from the study at any time up until analysis began. Participants were informed that they could stop or take a break at any time during the interview. Following this conversation of consent, we signed consent forms and participants provided with a copy of the signed consent form. Although discussion group participants were encouraged to keep the discussion confidential, participants were informed that confidentiality could not be guaranteed within the discussion group setting.

#### **4.6 Data Analysis: Feminist Poststructuralist Discourse Analysis**

There are many approaches to data analysis for qualitative research. The combination of a feminist poststructuralist perspective with a case study provided a unique opportunity to employ an approach to data analysis that can attend to the philosophical and epistemological demands of feminist poststructuralism and the pragmatism of case study. In order to attend to my feminist poststructuralist perspective, the data analysis methods incorporated two approaches, identified by Stake (1995) as ways that researchers find meaning. The analysis method will include both direct interpretation and data aggregation (1995).

I used feminist poststructuralist discourse analysis (Aston, 2016) to analyze the data collected for this study. Discourse analysis incorporated my feminist poststructuralist perspective in the analysis of the collected data about collaboration between midwives and nurses. Discourse analysis is a way of analyzing textual data within the context of its social, historical, institutional, and personal influences (Cheek, 2000).

This analytical approach was important for understanding collaboration between a newly regulated profession with a history of marginalization (midwifery) and an established, regulated

profession with a history of inclusion (nursing). Women dominate both of these professional groups in numbers, yet one group was incorporated into the institution of medicine in Canada (nurses), while the other was marginalized in Nova Scotia until 2009 (midwives). How have the historical, institutional, social and personal discourses shaped current experiences and perspectives of collaboration between these two professions in Nova Scotia? Discourse analysis was a way to explore and uncover the discourses that influence current collaborative practice.

Cheek (2000) asserted that one of the challenges with conducting discourse analysis is that there are no specific guidelines that outline the process of data analysis. Crowe (2005) echoed the sentiment that discourse analysis is not a step by step method. This was challenging for me as a novice researcher because of the need to demonstrate both rigour and a plan for analysis. I used Aston's (2016) feminist poststructuralist discourse analysis approach to guide the analysis for this study. To ensure rigour during the analysis, I directly consulted with Aston, who developed this approach to feminist poststructuralist discourse analysis, as well as my supervisor.

Analysis began with a thorough listening, reading, and re-reading of the transcripts. Next, I read each transcript individually and identified important issues as they related to collaboration between midwives and nurses in Nova Scotia. Along with identifying the issues, I also identified the corresponding beliefs, values, and practices of the participants, as they related to the issue and to collaboration between midwives and nurses. Examining beliefs, values, practices, and discourses has been used by researchers using discourse analysis as part of feminist poststructuralist approaches to research (Aston, 2016; Aston et al., 2016, 2014, 2015; Kohi et al., 2017; Macdonald et al., 2018; Mbekenga et al., 2018; Mselle et al., 2017). Exploring these factors within the text also aligned with how Crowe (2005) describes her approach to discourse analysis. Crowe (2005) argued that discourses shape beliefs, knowledge, and values, and

ultimately these influence ones' practices. After identifying the beliefs, values, and practices of the participants in the text, I examined how these combined factors related to social, historical, and institutional discourses (Aston et al., 2016, 2014, 2015). Of particular interest throughout these stages was how the identified issues in the text, and their corresponding beliefs, values, and practices, illustrated historical, social, institutional, and gender discourses. Also of interest was what was excluded from the text which required deep reflexivity in order to 'see' what was not being said. This stage of analysis coincides with what Stake (1995) refers to as direct interpretation, where the researcher is responsible for the interpretation of the data.

Once I had read all the transcripts and identified the issues and their corresponding beliefs, values, practices, and discourses, I began to weave together similar issues into groups that became sub-themes. This was a very iterative process, which involved choosing the most relevant issues and supporting quotations, from each transcript. I continually referred back to the original transcripts to ensure that I was mindful of the context of each quotation, and then arranged and re-arranged the groupings of similar issues into sub-themes (see Table 3). Even at this stage the groupings of issues into sub-themes were fluid, depending on the clarity and complexity of each issue.

Table 4 Feminist Poststructuralist Discourse Analysis

|            |       |           |
|------------|-------|-----------|
| Belief     | Issue | Sub-theme |
| Value      |       |           |
| Practices  |       |           |
| Discourses |       |           |
| Belief     | Issue |           |
| Value      |       |           |
| Practices  |       |           |
| Discourses |       |           |
| Belief     | Issue |           |
| Value      |       |           |
| Practices  |       |           |
| Discourses |       |           |

Following the identification of the sub-themes, similar sub-themes were aggregated to create themes. Each segment of text was analyzed for the beliefs, values, and practices within it. The segment of text was also analyzed using a feminist poststructuralist lens to consider how gender and power influenced the experience of the participants. Discourses in which the experiences described in the text occurred were identified as a further layer of analysis. It is important to note that sub-themes and themes were not the result of grouping similar discourses together. Similar issues were grouped according to similarity, which formed the sub-themes and themes, and the discourses provided further context to the text. Therefore, within a theme or sub-theme, there may be several different discourses influencing the values, beliefs, and practices of the participant's experiences. Although the findings were presented as 'sub-themes' and 'themes', unlike a typical thematic analysis process, this feminist poststructuralist discourse analysis involved additional layers of analysis and interpretations that included an examination of specific feminist poststructuralist concepts such as discourse, gender and power relations.

This part of the analysis involved a lot of writing, reflecting, and referring to the original transcripts and quotations to ensure that the issues, beliefs, values, practices, and discourse were

identified and reported consistently. I often challenged myself throughout this process about my own interpretations and insights of the data, asking questions such as; what does the participant mean by this...? How does the participant accept or challenge dominant discourses? What is not being discussed by the participants? Where are the tensions in the relations of power? In addition, power relations, agency, and subject positions were identified and described for each issue and its supporting quotation, depending on their relevance to the quotation. All issues that contributed to the sub-themes have been supported with quotations directly from the text of the transcribed interviews. Additional contextual information for the analysis was provided by reviewed documents, field notes, and literature. This process was reflective of Cheek's (2000) poststructuralist approach to discourse analysis where data was organized according to different issues and discourses. This stage of analysis was reflective of Stake's (1995) articulation of data aggregation where the researcher reviews data and organizes the data in a meaningful way in order to demonstrate an in-depth understanding of the case.

The data has been presented as themes and corresponding sub-themes. The context of each participant was captured through the use of quotations of their own words and analyzed in relation to their own beliefs, values, practices and subject positions, which reflected the intersectional approach found in feminist poststructuralism. As an instrumental case study, the individual contexts of each participant were attended to at the beginning of the analysis and throughout the analysis to create an in-depth understanding of collaboration between midwives and nurses in Nova Scotia. Although this has been described in a linear fashion, it is important to understand that the analysis was an ongoing and iterative process.

To ensure trustworthiness, I consulted with my supervisor and a committee member regarding the transcripts, analytical process, and construction of the findings. It is important to

recognize that the findings from this analysis do not reflect a universal understanding or meaning, but instead they provide a contextualized understanding of the text from my perspective as a researcher. These findings have the potential to be used to challenge current dominant discourses.

One way to address the challenge of not having specific guidelines to follow for discourse analysis is to ensure that rigour is attended to. Crowe (2005) developed methodological and interpretive rigour for discourse analysis in order to address the fact that multiple interpretations can occur from the same texts (see Table 4).

Table 5 Methodological and Interpretive Rigour for Discourse Analysis

| <b>Methodological Rigour</b>                                                                          |
|-------------------------------------------------------------------------------------------------------|
| Does the research question 'fit' discourse analysis?                                                  |
| Do the texts under analysis 'fit' the research question?                                              |
| Have sufficient resources been sampled, e.g. historical, political, clinical?                         |
| Has the interpretative paradigm been described clearly?                                               |
| Are the data gathering and analysis congruent with the interpretative paradigm?                       |
| Is there a detailed description of the data gathering and analytical processes?                       |
| Is the description of the methods detailed enough to enable readers to follow and understand context? |
| <b>Interpretative Rigour</b>                                                                          |
| Have the linkages between the discourse and findings been adequately described?                       |
| Is there adequate inclusion of verbatim text to support the findings?                                 |
| Are the linkages between the discourse and the interpretation plausible?                              |
| Have these linkages been described and supported adequately?                                          |
| How are the findings related to existing knowledge on the subject?                                    |

Methodological Rigour and Interpretative Rigour taken from (Crowe, 2005).

I used this framework to inform my reflexivity about my approach to the analysis as a means to ensure that I had used feminist poststructuralist discourse analysis rigorously. This reflexivity included journaling throughout the analysis, conversations with the methodological expert on the committee, as well as my supervisor. I also engaged in an ongoing process of questioning myself in terms of the findings. I also documented the analysis and maintained copies of the multiple

layers of analysis which I reviewed frequently and over time to ensure that the findings that were formed were consistent over time.

#### 4.7 Participant Demographics

There were 18 participants that were interviewed for this study. One participant withdrew from the study, following completion of the interview, upon realization that she did not meet the inclusion criteria. The following is a breakdown of participants in terms of participant type; 5 midwives, 6 nurses, 3 mothers, 3 stakeholders, 1 health care provider. The participant that withdrew was one of the Mother participants, who believed that a midwife and nurse had attended her home birth, but found out after the interview that she had actually been attended by two midwives. This meant that there was a total of 17 participants who completed interviews that were included in this study (See Table 5). The number of participants that were actually interviewed was less than the anticipated number of participants, this reflected the recruitment challenges associated with the suspension of midwifery services at one model site as well as the small numbers of midwives and health care providers who have opportunities to collaborate with midwives.

Table 6 Actual Number of Participants Interviewed

| <b>Participant</b>             | <b>Anticipated number of participants</b> | <b>Actual number of participants</b> |
|--------------------------------|-------------------------------------------|--------------------------------------|
| Midwife                        | 7                                         | 5                                    |
| Nurse                          | 7                                         | 6                                    |
| Mother                         | 3-4                                       | 3                                    |
| Stakeholder                    | 3-4                                       | 3                                    |
| Health Care Provider Colleague | 3                                         | 1                                    |
| Withdrawn                      |                                           | -1                                   |
| Total                          | 23-25                                     | 17                                   |

Participants who were interviewed based on their professional backgrounds (midwives, nurses, stakeholders, health care providers) had a variety of levels of practice experiences. These

participants had worked in their current position for 1 to 10 years, and had a variety of experience working in their field, with participants working between 1 and 38 years in their field (See Table 6).

Table 7 Years of Practice of Participants

| <b>Years of Practice (Midwives, Nurses, Stakeholders, Health Care Providers)</b> |   |                             |   |
|----------------------------------------------------------------------------------|---|-----------------------------|---|
| <b>Current Position</b>                                                          |   | <b>Total years in field</b> |   |
| 0-2 years                                                                        | 5 | 0-2 years                   | 1 |
| 3-5 years                                                                        | 4 | 3-5 years                   | 4 |
| 6-10 years                                                                       | 6 | 6-10 years                  | 1 |
| 11-15 years                                                                      | - | 11-15 years                 | 2 |
| 16-20 years                                                                      | - | 16-20 years                 | 2 |
| 21-30 years                                                                      | - | 21-30 years                 | 1 |
| 31-40 years                                                                      | - | 31-40 years                 | 4 |

In terms of levels of education, participants had a variety of educational backgrounds (see Table 7). Two participants had diplomas or certificates, in addition to undergraduate degrees. Between all participants 21 undergraduate degrees were held. This number was higher than the total number of participants because six participants had more than one undergraduate degree. Amongst all the participants, there were six graduate degrees that were held by six different participants. One participant indicated that she is currently enrolled in a graduate education program.

Table 8 Levels of Education

| <b>Indicated levels of Education (All participants)</b> |    |
|---------------------------------------------------------|----|
| Diploma/Certificate                                     | 2  |
| Undergraduate (Bachelor)                                | 21 |
| Graduate (Master)                                       | 6  |

There were two participants who were interviewed due to their experiences of collaboration between midwives and nurses as mothers. Both mothers indicated that they received care from both a nurse and a midwife during their labour and delivery (see Table 8).

One participant indicated she received postpartum care from both a nurse and a midwife.

Interestingly, two nurse participants shared that they had received perinatal care from midwives.

Table 9 Perinatal Care Provided to Mothers by Midwife and Nurses Together

| <b>Type of care provided to Mothers by Midwife &amp; Nurse together</b> |   |
|-------------------------------------------------------------------------|---|
| Labour                                                                  | 2 |
| Delivery                                                                | 2 |
| Postpartum                                                              | 1 |

Participants were recruited based on their associations with the three model midwifery sites within Nova Scotia. In order to maintain the participants' confidentiality, a breakdown of the type of participants associated with each of the model midwifery sites will not be provided. In addition, any distinguishing information collected in the demographic profile will not be reported in order to maintain participant confidentiality.

#### **4.8 Trustworthiness of Data**

Lincoln and Guba (1985) described four key criteria for assessing the trustworthiness of qualitative research data. The four criteria are; credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility refers to one's confidence that the findings reflect the truth as reported by the participants at the time of data collection (Lincoln & Guba, 1985). Transferability refers to one's confidence that the findings could be applied in another setting or context (Lincoln & Guba, 1985). Dependability refers to one's confidence that the study could be repeated and that the findings would be similar (Lincoln & Guba, 1985). Finally, confirmability refers to one's confidence that the findings are representative of the collected data from study participants and not solely the views or values of the researcher (Lincoln & Guba, 1985).

Creswell (2018) describes eight strategies for validating qualitative research in order to determine the accuracy of the findings that are reported by the researcher. The eight strategies

are; prolonged engagement and persistent observation, triangulation, peer review or debriefing, negative case analysis, clarifying research bias, member checking, rich thick description, and external audits (Creswell & Poth, 2018). Depending on the design of the study and the validation criteria being addressed, there will be instances when strategies are used independently and in combination.

I attended to credibility through the use of multiple sources of data collection and through discussions with participants after analysis as a means of providing an opportunity for participants to provide feedback about preliminary findings (Creswell & Poth, 2018). Sharing the preliminary findings with participants also aligned with feminist principles of research which emphasize collaboration and interaction between researcher and participants (Polit & Beck, 2012). Transferability was addressed through the use of thick description of the findings and overall case (2018). Dependability was attended to through the use of my field notes, which included recording observations during interviews, and journaling as sources that created an audit trail (2018). Confirmability was addressed with an audit trail which was recorded in the field (2018).

I kept a journal within the field notes throughout the entire study to document my thoughts, ideas, and feelings throughout the research process. The aim of journaling throughout the conduct of research was to engage in reflexivity (Creswell & Poth, 2018). Conducting qualitative research meant that I was the research instrument (2018), intricately linked to the research. Maintaining a journal, within the field notes, ensured that I was reflective and accountable in my role as researcher.

I interviewed a few participants with whom I already had an existing professional or personal relationship. I was concerned about simultaneously maintaining a professional approach

and open approach with an interviewee I was already acquainted with. Garton and Copland referred to interviews conducted between a researcher and participant with a pre-existing relationship as ‘acquaintance interviews’ (2010, p. 535). My strategy for interviews with colleagues or acquaintances was to begin the data collection by first interviewing some participants with whom I did not have a pre-existing relationship. This practice allowed me to get comfortable interviewing participants generally (Polit & Beck, 2012), without the added pressures of potentially interviewing people I knew. I also ensured that clear boundaries and expectations were identified prior to the beginning of the interview to assist with the maintenance of professionalism.

#### **4.8.1 Limitations.**

This qualitative case study reflects the experiences of participants in this study. It is important here to remember that these findings are not generalizable. The goal of this qualitative case study was not to generalize, but rather to develop a deep contextual understanding of collaboration between midwives and nurses in Nova Scotia. Although the findings are not generalizable, others may be able to use these findings to better understand collaboration between midwives and nurses in different contexts throughout Canada, and perhaps globally.

#### **4.9 Dissemination**

I will use multiple dissemination strategies to share the findings of this study. The first approach will be to ensure that a written report of the study is provided to all the participants, and participating organizations and institutions. Secondly, manuscripts will be written and submitted to national and international journals for publication. Thirdly, I will share study findings at national and international conferences and I will also make myself available for less formal discussions and presentations.

After successful completion of my doctoral degree, I aim to apply for dissemination funding in order to disseminate the findings in creative and publically accessible methods. Possible modalities may include; video clips shared through social media, artwork, theatre, poetry, dance, and music. The chosen modalities will highlight the findings and focus on how collaboration between midwives and nurses can support the sustainability of midwifery to ensure equitable access to midwifery care for all Nova Scotians and Canadians. My goal is to create a campaign that will be accessible to the public and distributed to local and national audiences.

## **Chapter 5: Findings**

There were a total of four main themes and eleven corresponding sub-themes (see Table 9). The main themes reflected how; midwives and nurses negotiated their roles and practices, sustained their relationships, reconciled systemic tensions, and how collaboration between midwives and nurses provides a foundation for innovative models of perinatal care. In keeping with the principles of feminist poststructuralist discourse analysis, these themes and sub-themes were developed from grouping similar issues identified in the text. An issue was identified for each segment of text, which was then more closely examined for the beliefs, values, and practices expressed by the participants (see Table 3). Social, institutional, and historical discourses that influenced the issue identified in each segment of text were identified, as well the influences of gender, power relations, and subject positioning, and how language was used to describe the meaning of the issue. These additional layers of analysis, using feminist poststructuralist concepts, make feminist poststructuralist discourse analysis different from a typical thematic analysis process. I will present each of the main themes and their corresponding sub-themes within the context of relevant discourses.

Table 10 Themes and sub-themes

| Main Theme                                                                                                        | Sub-themes                                                              |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Negotiating roles and practices: 'Every nurse is different, every midwife is different, every birth is different' | 'A constant negotiation' of roles                                       |
|                                                                                                                   | 'Crossover' of skills and practices                                     |
|                                                                                                                   | Communication and 'good anticipating'                                   |
| Sustaining relationships: 'The more we can just build relationships with one another'                             | Testing trust, 'if they did not trust us, they would not sign up.'      |
|                                                                                                                   | Midwives depending on nurses, 'we could not do our job without them.'   |
|                                                                                                                   | Needing more opportunities together, 'they are not the unknown anymore' |
| Reconciling systemic tensions: The medical model and the midwifery model                                          | The (in)visibility of collaboration & 'the best kept secret'            |
|                                                                                                                   | Resisting and accepting institutional expectations                      |
|                                                                                                                   | The 'medical approach versus the midwifery approach'                    |
| Moving forward: A modern model for nurses and midwives working together                                           | 'The (birthing) culture has changed'                                    |
|                                                                                                                   | Advocacy, 'allies and advocates'                                        |

### 5.1 Negotiating Roles and Practices: 'Every Nurse is Different, Every Midwife is Different, Every Birth is Different'

Midwives and nurses negotiate their roles and practices when they collaborate in Nova Scotia. This negotiation of roles and practices reflects the ways that midwives and nurses accommodate the needs of each other as professionals, the needs of the women and their families, and the needs of the settings in which they work. The sub-themes that contribute to this main theme are; 1) 'A constant negotiation' of roles, 2) 'Crossover' of skills and practices, 3) Communication and 'good anticipating'.

### 5.1.1 'A constant negotiation' of roles

All the participants in the study talked about the roles and practices of midwives and nurses who work together in Nova Scotia. Many participants had clear understandings of the roles of midwives and of nurses in a health care system that included both professions for the delivery of perinatal health care services. Although there appeared to be a clarity of roles for many participants, there were many participants for whom the role of a midwife and the role of a nurse required flexibility when they worked together. In this context professional roles appeared to be under an ongoing negotiation between nurses and midwives.

The midwife participants in the study talked about their role as primary health care providers. They believed they had a responsibility as primary health care providers and worked hard to balance that responsibility with an equal sharing of work with the nurses. Florence, a midwife participant talked about this clinical responsibility to her license and to her clients,

I feel like for me when, and I can only kind of speak to me, when I am in a birth space I feel like I am managing that birth, but I feel that the roles and the support and the work that is taking place is very equal. But ultimately I'm still the one responsible, so clinically I am responsible and I can't forget that. And I'm clinically responsible to my license, but also responsible for the woman who I've gotten to know, who I'm aware of what she wants, and I have to listen to her for six weeks after if she doesn't get what she wants, right? (Florence, Midwife)

Florence believed that her role and the role of nurses, as well as the work that they did together was equal. She also believed that as a primary care provider, she was clinically responsible at births. These two beliefs created a tension for her, because she valued the equality of the role and work she did with nurses, but she was positioned as clinically responsible in her role as a

midwife, and primary care provider. In a medical discourse of role hierarchy, primary care providers have authority and therefore overall responsibility for the safety of women.

Historically, male physicians were primary health care providers. In a midwifery discourse of roles, the client is considered the expert of their body and experience and the historically females midwife's role is to facilitate the client's experience in terms of decision making, clinical and supportive care. In the midwifery discourse, hierarchy is minimized and clients, midwives and other health care providers work together in partnership. Florence valued her midwifery license, which positioned her as a primary health care provider within a medical discourse of the hierarchy of roles. She also valued her clients' needs, believing that she was had a responsibility to the women in her care, which reflected her alignment with a midwifery discourse of roles. Although she believed the work with the nurses felt equal, which reflected the influence of a midwifery discourse, she also claimed clinical responsibility for births, which reflected the influence of a medical discourse of role hierarchy. She had to remind herself that she was clinically responsible at births to ensure she worked within the medical discourse, as she was professionally socialized, as a midwife, within a midwifery discourse where hierarchy was minimized. As a primary health care provider, Florence challenged historically gendered discourses of the hierarchies in medicine which privileged (male) physicians over (female) nurses because she embodied a primary health care provider role from a historically female dominated profession, midwifery.

Within an established medical system, nurses had experiences working with a variety of health care providers, and generally understood the roles and expectations of primary health care providers. For Elisabeth, a midwife participant, the nurses' understandings and experiences of working with other health care providers was a more effective reference point for her when she

worked with nurses, rather than protocols or guidelines that delineate which profession was responsible for certain tasks or practices.

Yeah, I think it's just a mutual understanding. I know when we started there was a big protocol - this is what a midwife does and this is what the nurse does. But it never worked out. I mean, I think we are the primary care provider and that's what nurses know. And we are also attached to this woman, so that's the one thing, how to include when you go in with the nurses. But this is usually working very well. And then there are nurses that really totally like to be involved and being hands-on and that's okay, and there are other nurses they feel - no, she can do it. And that's okay as well. And for example like checking baby's heart rate is ... yeah, if I think about it I do it, if the nurse thinks about it. If I'm doing something or at the end and I feel, oh, we should have a heart rate, and I can ask the nurse - can you check the heart rate? (Elisabeth, Midwife)

Elisabeth believed that there was a mutual understanding between nurses and midwives about what their roles were, and that a protocol developed to outline the jobs and responsibilities for midwives and nurses did not work. A tension was created when a protocol was created that outlined the clinical tasks for midwives and nurses. The tension was between being told how to work together and working together flexibly. In a medical discourse, policies and guidelines are valued for outlining procedures and expectations with regards to clinical tasks and professional roles. As formal documents, they are often considered inflexible terms for collaboration and reinforce a hierarchy of roles. In a midwifery discourse, flexibility and adaptation are valued because of the need to provide care to clients in a variety of settings, with a variety of people, and using a variety of resources. Although guidelines and policies are important in midwifery, they are not directives for care. They are adapted based on the wants and needs of the client, as

well as the context in which labour and birth are taking place. Elisabeth aligned herself with a midwifery discourse and incorporated flexibility and adaptability in her practices in order to accommodate the practices of nurses, depending on which discourse they aligned themselves with. Elisabeth recognised that some nurses were aligned with a medical discourse that reinforced a hierarchy of roles. When that happened, she adapted her practices to accommodate the nurses' practices within the medical discourse. Elisabeth's flexibility to adapt to the nurses' practices helped to minimize the tension created by formal protocols regarding professional roles and corresponding clinical tasks.

In Nova Scotia, midwives have been integrated into perinatal health care services as primary health care providers. Most of the nurse participants in this study recognized midwives as primary health care providers and understood that this role assumed a level of responsibility that nurses, who are not primary health care providers, do not have. One nurse described her understanding of the role of the primary health care provider and how that understanding influenced the way that she worked with midwives in a hospital,

I always feel like the primary care provider's like the boss, not that we have to do what they say, but that the instructions and the plan and the goals are coming from them. And so oftentimes the onus of making sure that this family's going to be safe when they go out into the community, that's on them. So that's something that I try not to focus on in my care. I just try to focus on what I could do right now at this point and I'll make sure it works in the end. And so in that sort of sense definitely the midwives are the ones who are directing the care and deciding what's important for them, what their discharge goals are going to be, how much follow-up the patient's going to need, yeah, what we need to get done before they're safe to go home, before they're feeling ready to go home

as well or something. And then we're not necessarily in a subordinate role, but in a role where we're just trying to support that to make... to make those goals happen. (Mary, Nurse)

Mary believed that midwives, as primary care providers, were ultimately responsible for the safety of patients when they were discharged from hospital. She valued midwives as primary care providers. Mary accepted an institutional discourse of role hierarchy amongst health care providers. She accepted midwives in their role as primary health care providers who directed the care and determined discharge goals and plans for follow-up. Mary believed that nurses were not in a subordinate role, but her practices did not reflect her belief because she used the directions and instructions from the midwives to determine her clinical practices. Mary worked within a medical discourse where health care provider roles are ordered hierarchically, with nurses (often female) located below primary care providers (historically male physicians). Mary's beliefs and practices reflected a tension between the medical discourse and a professional nursing discourse where nurses are positioned in places of both professional autonomy (nursing discourse) and clinical subordination (medical discourse). In the nursing discourse, nurses believe that they have autonomy over their own practice and their capacity for clinical decision-making. This is different from medical discourse in which primary care providers provide 'orders' to nurses and determine overall plans of care for patients. Mary stated that nurses were not subordinate to primary care providers, yet she relied on their direction to determine her own practices. This illustrated Mary's conflict between her acceptance of primary care provider directions for care and her own professional and clinical autonomy. Mary's conflict also illustrated an historical tension within nurses discourses between discourses of clinical autonomy and discourses of subordination within the gendered hierarchies of medicine.

The positioning of nurses in a supportive role was articulated by several participants in the study who described nurses as; complementing, supporting, or assisting, midwives and clients. Specific to nurses who attended home births as RN Second Attendants, Susan described how nurses were expected to complement the midwife and respect the relationships that the midwife had developed with the client and family in her care,

And I think the nurse, the RN Second Attendants really respects the relationship that the midwife has already established. She's been already with this family for maybe hours before the RN Second Attendants has arrived. So it's important, and it doesn't devalue the role of the nurse because the midwife might ask the nurse to do certain tasks. And that's the respect that the nurse has that she is there to complement what's happening, not to sort of takeover or change the mood. It's to fit into the mood. (Susan, Stakeholder)

Susan valued the nurse's role as a RN Second Attendant and she valued the midwife as a primary care provider. Susan believed that the nurses' role, as an RN second attendant, was complimentary at a home birth. For Susan, this meant that nurses needed to fit in at home births. In a traditional medical discourse, nurses, the majority of whom have been women, are positioned as helpmates to physicians, the majority of whom have been men. Historically in this medical discourse, a nurse's role was to support and assist the physician and patient. In a midwifery discourse, there has historically been no helpmate to the midwife because the midwife is positioned to support the client, her body, her choices, and her needs. Susan's expectation that RN Second Attendants 'complement' what was happening at a home birth was influenced by the medical discourse which positioned nurses to assist or support primary care providers (historically male physicians) and clients, rather than direct client care.

Jean, a nurse participant who attended home births with midwives as a RN Second Attendant believed that the RN Second Attendant role was different from the role that a nurse has in a hospital setting. She believed that she was more of an 'assistant' to the midwife at home births.

So yeah, quite a different role. And I guess it's a role more of safety and having someone who can help with a resuscitation or know where the things are, know how to draw up whatever the midwife might need at the time. So it's much more an assistant kind of role. And if I'm not needed then I'm not needed. So it would be observing and just being there... Fine, it took a little bit to get used to that and understanding it, because you're not kind of taught ... it's an experiential kind of thing. But once you know what the role is it's fine... (Jean, Nurse)

Jean valued her role as a RN Second Attendant and she believed that the RN Second Attendant role involved the skills to assist at the birth with skills that could ensure safety. In a medical discourse, the hospital is believed to be the safest place to have a baby because it has access to emergency equipment and many health professionals with emergency expertise. In a medical discourse, home birth is unsafe. In a midwifery discourse, home is a safe place for low-risk women to have babies. Midwives who attend home birth have emergency skills and equipment that would be needed in an emergency situation, and have guidelines for transferring women to a hospital for anticipated emergencies. There was a tension for Jean because she positioned herself as a RN Second Attendant for home births which placed her work within a midwifery discourse of believing that home birth was safe. Yet, she also believed that her role was one that was concerned with safety, where she had the skills and knowledge to anticipate and react to emergencies such as a need for resuscitation. Jean positioned herself as a guardian of

safety in her role as a RN Second Attendant at home births, and she negotiated two discourses about safety and birth. Her role as a Second Attendant at home births reflected her alignment with the midwifery discourse of home birth as a safe birthing option. Yet her belief that her role as a Second Attendant was primarily concerned with safety at home births, reflected a medical discourse of concern for safety. She talked about the challenge of learning her role as a RN Second Attendant for home births through experience. As a nurse with experiences working within a hegemonic discourse of hospital birth, she was not taught how to be a Second Attendant for home births, because home births were considered unsafe, and were therefore not an environment in which she was used to delivering care.

Common among most of the participants was the flexibility or fluidity of the midwifery and nursing roles. Although midwives and nurses knew what their own roles were and often what the roles of the other provider was, there was room to negotiate these roles in order to accommodate the different needs of clients, families, birth settings and each other as health care providers. Colin, a midwife participant, believed that there was a 'constant negotiation' of roles and expectations in order to ensure that midwives and nurses did not 'abuse' each other by making assumptions about each other's practices.

And but, it also means that it's super important that we're communicating well, and that respect is existing on both sides. That they understand our role and when we need their help, and that they're there and that they have our back and that the same, that I'm not asking them to do more than is fair and the same for them. Because there is room there to abuse each other to say, I don't need to do that, the midwife will do it, or I don't need to do that the nurse will do it. We really are always having to finesse in a really busy life - what is your role and what is my role and what is fair for me to do and what is fair for

you to do? And if I'm exhausted can you step up and do a little more? And if you guys are overwhelmed can I step up and do a little more? It is really a constant negotiation. It's not perfect. (Colin, Midwife)

Colin believed that the flexibility to accommodate each other's needs and the needs of clients, meant that midwives and nurses were constantly reflecting about their roles and negotiating what was fair for each of them to be doing within the context of each birth. This 'finesse'ing or 'constant negotiation' occurred in addition to the routine expectations of the delivery of perinatal care. For Colin, communication and respect were crucial for this negotiation, and even when communication and respect were present, the process was not without challenges. In a midwifery discourse, flexibility is an important aspect of one's practice. A provider working within a midwife discourse is flexible to the variations in the needs, spaces, and contexts in which clients' birth. In a medical discourse, the primary care provider is flexible within the context of the structure of the hospital institution. The location of birth, resources, professional roles, and personnel are familiar, standardized, and governed by the policies of the institution. However, at the same time, within a nursing discourse, nurses are required to be flexible to the needs of both the primary health care provider and the client because of the historically gendered socialisation of (female) nurses to fill a supportive role for (male) physicians. Colin and the nurses she worked with challenged the medical discourse because they communicated with one another in a 'constant negotiation' about their roles and practices. Their roles and practices were not standardized, instead of being governed by the institution, they were governed by the needs of the client, the needs of Colin and the nurses, and the context of the birth.

Although the majority of participants articulated clear understandings of role expectations and a flexibility to negotiate each other's needs within the various contexts of providing perinatal care, there was one participant for whom the roles of midwives and nurses was not clear. For Emma, a service user participant, did not have a clear understanding of the differences between the midwife and nurse roles at her hospital birth.

Yeah, so I was ... Look, I did know going into it that it would be like the midwives would be the ones who would ... like [the midwives] they reassured me like that they would be doing like most like everything. But I guess ... Yeah, maybe I wasn't aware of what the nurse's role would be. So I think maybe ... and I've had so many visits with the midwife, that was one of the things I enjoyed, and all of the many visits that I did go ... So we did talk about a lot, so maybe they do share the nurse's role and I just didn't catch that. But I think it would be helpful to understand like the difference between the nurse and the midwife and what their roles are and kind of expectations around that. (Emma, Service User/Mother)

Emma believed that she did not understand the role of the nurse when she worked with a midwife. She valued reassurance from her midwife that the midwife would be providing most of her care, but she believed it would be helpful to understand how midwives and nurses were different in terms of their roles. A hegemonic social discourse of birthing care provides the expectation that nurses provide clinical and supportive care during labour and birth, with a physician present for the delivery. In a midwifery discourse, midwives provide clinical and supportive care throughout the perinatal period. During labour and birth a midwife's practices of supportive and clinical care may overlap with a nurse's practices, because the midwife is present for more of the labour than a physician typically is. Midwives as an alternate primary care

provider have not become part of the hegemonic social discourse of birthing care, likewise nurses have not fully become a part of the midwifery discourse of birthing care in hospitals in Nova Scotia. Emma believed that more information about what nurses' roles and the expectations of their practices, when they work with midwives, would have been helpful for her in understanding the difference between midwives and nurses. Emma's experience reflected the invisibility of the ways in which nurses collaborated with midwives in both the social and midwifery discourses of birthing care.

### **5.1.2 'Crossover' of skills and practices**

In terms of how midwives and nurses practiced, all participants talked about how the practices and skills of midwives and nurses were similar, with many participants observing a great deal of crossover. Midwives and nurses worked hard to remain flexible to each other, the needs of the birthing woman and her family, and the environment in which they worked. Participants believed that there were occasions when specific skills or tasks were better performed by one or the other profession, and this was determined at each birth by the midwives and nurses.

The majority of participants talked about how the skills and practices of midwives and nurses were similar and often overlapped when they worked together. Chelsea, a midwife participant, talked about her belief in the similarities and 'crossover' of skills with nurses, and how this belief influenced her approach to working with nurses in a hospital.

It really does, crossover quite a bit.... The skill set. Like the actual clinical skill set, as well as the supportive care piece because typically nurses are doing all the supportive care until a doctor comes in and catches a baby. So with midwives because we're there once the client is established in her active labour, some nurses really enjoy that, that

supportive care piece and aren't sure then what their role is. So I do always try to have a chat with a nurse as we're getting settled in to say like 'you do what you do and I'll just follow your vibe and my client's vibe. I'll kind of work around you all.' (Chelsea, Midwife)

Chelsea believed that there was a crossover of clinical skills and supportive care between midwives and nurses and she believed that the presence of midwives during active labour and their participation in providing supportive care led some nurses to question what their role was at a birth. Chelsea was aware of a medical discourse of birthing care, where nurses were present for the entire labour and birth, and provided clinical as well as supportive care. In the medical discourse of birth, perinatal nurses provides continuous labour, birthing, and postpartum support in consultation with a physician (the primary care provider), who often has intermittent presence throughout labour and a committed presence at the time of delivery and immediate postpartum period. In a midwifery discourse, the midwife is present for the labour and birth, and they provide clinical and supportive care to the client. The midwife catches the baby and is present for the immediate postpartum. When nurses worked with midwives their roles and the timing of their practices overlapped. In response to the tension of nurses questioning their role when they worked with midwives, Chelsea initiated a conversation about her approach to sharing the work with the nurse and following the nurses lead. Chelsea believed that for some nurses, working with midwives who were aligned with a midwifery discourse of providing care was challenging for them because they were aligned with a medical discourse. Chelsea valued collaboration with nurses and her actions to include and 'work around' the nurses in the hospital demonstrated her commitment to inter-professional collaboration. This was particularly noteworthy because as a

primary care provider she could have used her agency to take charge and direct the practices of the nurses.

Although Chelsea valued negotiation with the nurses about who would perform certain clinical skills, she also believed that there were some skills that are ‘normally’ performed by nurses. For those clinical skills, she was careful not to ‘take it away’ from the nurses because she did not want to disturb how that skill may be an identity marker for a nurse,

In terms of clinical skillset, sometimes it just a ‘oh hey do you want me to do that?’ or ‘oh hey do you want to do that while I do this?’ So it's a, you really need to be able to communicate that really clearly because then if you don't, I would hate for the nurse to assume that I'm going to start an IV when normally that's their job. But even though it's a skill that I have and I sometimes want to do to keep my skill up, I don't want to take it away from them and sort of them identifying themselves in their role in the space. So I'm really mindful, or at least I try to be super mindful of that. Sometimes there's no time for it but I do always try to.... rather than identify like a boundary - like this is where your role ends and mine begins. Have it more collaborative, working together we may both do some of this and that's okay, and kind of going from there. (Chelsea, Midwife)

Chelsea's flexible approach to the negotiation of clinical skills and practices reflected her alignment with a discourse of person-centered care, which aims to hold space for respectful, healthy, and empowering relationships between health care providers, services users, and others involved during the continuum of care for a client. Chelsea believed in collaboration and the flexibility of roles. However, she also believed that some nurses may connect certain skills to their nursing identity. Although she aligned herself with a midwifery discourse of flexibility of roles and skills, she also made space for nurses who aligned themselves with a nursing discourse.

In a nursing discourse, certain skills such as initiating IVs and providing supportive care during labour are considered skills that nurses have and skills that are typically nursing responsibilities. Chelsea believed that there may be practices that were important for nurses to perform in terms of their identity, and she was mindful of that when they were practices that she was capable of doing. Nurses' and midwives' work has been historically gendered with a focus on supportive and caring tasks. However with the regulation of midwifery, midwives have been validated as primary care providers with greater autonomy in their practices than nurses. Midwives appear to unify the historically gendered division of tasks and roles in perinatal health care between nursing and medicine due to their position as primary care providers with expertise in supportive care. Chelsea was aware of her unique position due to the crossover in practices with nurses and her position as a primary health care provider, and she remained flexible in the ways she collaborated with nurses to account for this.

For Daisy, a nurse participant, flexibility of clinical practices was important in order to adapt to what was happening during a home birth. The 'scenario' informed how Daisy provided care and where she was most needed during a birth. She believed that her experience as a labour and delivery nurse contributed to her comfort and ability to be flexible at each birth,

The mom is delivering, the midwife assists her. And sometimes both of us are there at the perineum, sometimes I'm just standing off to the side, it just depends on the scenario.

And I don't know, it's one of those things I'm comfortable I think because of my years of experience in labour and delivery, but also because I believe in those midwives and what they can do. So I'm never in a panic about a delivery and having everything be perfect, like a baby comes and they don't need much, they need mums arms, you need a warm

blanket, and they're ... I just find like we just naturally ... we know what has to be done, so if she's doing one thing I'll do the next. And it works well I find. (Daisy, Nurse)

Daisy believed in her own clinical practice because of her experience and she believed in the clinical practices of the midwives. Daisy aligned herself within a midwifery discourse of birth. In a midwifery discourse of birth, care providers must be flexible to the needs of the birthing person and the different spaces in which birth may occur. There is a belief that birth is a normal process unless otherwise indicated. Daisy was flexible and adapted to the needs and context of every birth. She was also aligned with a midwifery discourse because she shared the belief that birth is a normal process. This meant she was able to anticipate client and midwife needs at births.

Most of the participants believed that every birth occurred within different contexts. Annabelle, a midwife participant, talked about how midwives and nurses where she worked believed that there was some crossover of skills between the professions. This crossover was reflective of the difference in the practices of nurses and midwives, and the different contexts in which births happen. In order to address this crossover directly, Annabelle described how she initiated a conversation with the nurses about what she would like them to do at hospital births.

Yeah, what we've kind of decided here, I think is we're just going to keep it really open and there's going to be some crossover and with the nurses. And every nurse is different, every midwife is different and every birth is different. So afterwards we've come to, after a couple years here, what's worked well for me is just be like 'This is what I would like you to do after the baby's born: it's this, this and this and this and I may need you to do this and this just depends on how things are going.' So or they say 'Do you want us to do A, B C or D?' 'Like you know what, you do A and B, I'll do C and D, that's fine.' If it's busy or if I'm tired, that's a totally different discussion where if you know if it's been a

really quick labour there's nobody else delivering on the floor, I feel really rested because I feel like I can do a lot more of the things. But if I've been up all night, 'I might need you to do a few more things' and that's always worked well really well. (Annabelle, Midwife)

Annabelle, believed that addressing the potential crossover of skills and practices directly by communicating her expectations to the nurse at each birth worked well. Annabelle valued the crossover of her skills and practices with nurses because it meant that she could be flexible in her own practices depending on the context in which she worked. In a midwifery discourse, the midwife or care provider, must be flexible in terms of the client's needs, the people she works with, and the space she works in. Working within a midwifery discourse, Annabelle extended this flexibility to her own clinical practices when she worked with nurses, and communicated with the nurse to determine who conducted certain practices or completed certain tasks.

Annabelle believed that each nurse and each midwife was different, much like every birth was different and that these differences required the providers to be clear in their communication about which tasks they conducted.

From a service user perspective, Claire talked about her home birth and she believed that collaboration between the midwife and nurse at her birth was 'flawless.' Claire believed that the midwife and the nurse 'traded off easily,' the necessary tasks of birth.

I just feel like it was really flawless the way that they work together and the way they had a really positive kind of friendly rapport with each other. It was just a really pleasant environment, because they were just ... they were very friendly toward each other and they really traded off easily. It was just like, "Oh, you've done that. Great, thank you so much. And I'll do this thing." And it was nice even to hear them just discussing what they would do and how they would accomplish things, because it again just made it very

comfortable and I felt so confident in what they were doing. And I think like the culmination for me was when I was pushing and just having them both like be so supportive and the way that they both talked to me and the way that I felt in that like really challenging moment, and just how they were so in sync. . And even like talking to each other while I was pushing about what they were seeing and what was happening, I felt really good about it and I felt really encouraged by it. (Claire, Service User/Mother)

For Claire, flexibility and sharing of skills and practices, between the midwife and the nurse contributed to her positive birth experience. Claire valued the communication between the nurse and the midwife as they negotiated and shared tasks of her care. She was confident and comfortable with their care for her. In a person-centered care discourse, a client is treated with respect and included in all aspects of their care. This respect is extended to other participants in the care of the client, and everyone's contributions are valued. Claire's homebirth occurred within a discourse of person centered care, where Claire was a part of her care and the collaboration that occurred between the nurse and the midwife at her birth, this had a positive influence on her experience.

### **5.1.3 Communication and 'good anticipating'**

Almost all of the participants discussed communication as an element of practice that was important for collaboration between midwives and nurses in Nova Scotia. Participants described different aspects of communication between midwives and nurses, including how communication occurred, instances when clear communication was appreciated, and the importance of communication for anticipation of provider or client needs. Communication was valued by participants in the ways that it impacted professional relationships between midwives and nurses, and birth experiences for families.

Sunny, a doula participant, described how a midwife communicated to a nurse when a mother, labouring at home, progressed faster than expected and quickly made her way to the hospital.

And of course called on the way so that the nurse ... So that they were ready for this mom. But the nurse was given very specific directions, there was no time for chit-chat, she knew that it was business and go time. And again, just super professional prompt delivery of service that was needed. And then afterwards everybody could laugh about it and do the exhale. But again, I feel like, yes, that was like a potentially stressful thing for a nurse to be thrown into, but they're brilliant. They're brilliant at it and she knew that the main clinical aspects of that woman's care had already been offered, that she knew exactly how many centimeters dilated this mom was, she knew she didn't have to be asking questions of this mom because she had been given that preliminary care. ...By the Midwife at home, yeah.. (Sunny, Health care provider colleague/Doula)

Sunny believed that the midwife had called ahead to make sure the nurses at the hospital were aware and could be ready for the arrival of a woman whose labour was progressing quickly. Sunny observed that the midwife providing the nurse with specific directions about what she needed the nurse to do. In this situation there was no time to negotiate roles, skills, or who would address which tasks. In a medical discourse of the hierarchy of roles, the primary health care provider often directs the care of the client, and nurses who are located lower in the hierarchy are tasked with supporting the plan of care that is determined by the primary care provider. In Sunny's experience, the midwife positioned herself as the primary care provider, within this medical discourse of the hierarchy of roles, who communicated clearly to the nurse regarding the specific tasks that needed to be done. The nurse responded quickly and professionally to the

midwife's clear and direct communication, illustrating her acceptance of the hierarchy of roles discourse in that moment. Sunny believed the midwife used her knowledge of the client who she had clinically assessed to inform how she directed the nurse's clinical practices.

Florence, a midwife participant, explained how she called the hospital, when she knew she had someone in labour, to let the nurses know that a midwifery client would arrive at the hospital soon. She believed that this 'heads up' helped the nurses to prepare for the arrival of the birthing person, and it helped her because the nurses knew there were specific clinical tasks that Florence preferred to do herself.

But it's so good now, so what collaboration might look like is I have somebody who's called me and they're in labour, and I'm going to meet them at the hospital, but I would call ahead to let the early labour unit know that they're on their way in. So for me I feel like that's courteous, I'm giving them a heads up, this is who's coming in. They also know that, oh, [Florence] is coming in to look after her patient, we can do a few things for her if the patient gets here before she does. But we know that we don't have to do all of it, because [Florence] might want to do the vaginal exam herself. (Florence, Midwife)

Florence believed that calling ahead to let the nurses know that she had a midwife client in labour was 'courteous,' meaning that it was not an expected part of her role. Communicating with the nurses helped Florence to be involved from the beginning of a client's care in a hospital because the nurse's knew her preferences to conduct certain clinical assessments herself. In a medical discourse of a client's course of birthing care, a patient arrives at the hospital, the nurse assesses the patient, and then the nurse updates the physician about the patient's labour status. In a midwifery discourse regarding a hospital birth, the client often calls her midwife first to let her know she's in labour before going to the hospital, the midwife may call ahead to the hospital to

notify the nurses that a client will be arriving, the client arrives, and then the nurse and/or the midwife assesses the client. Florence aligned herself with a midwifery discourse of birthing care for hospital births, where she had communicated with the client prior to the client's arrival at a hospital and then called the unit to update them. Florence's practice of notifying the nurses prior to the arrival of a midwifery client in labour challenged her understanding of nurse practices informed by the medical discourse where a nurse would first assess the client and then inform the primary care provider of the client's status in labour. By communicating her knowledge of the client's status to the nurses, Florence protected her preferences to conduct certain clinical assessments, such as vaginal examinations, herself. Florence believed that providing the nurses with a 'heads up' benefited her, the nurses, and the clients. It also reinforced her position as the primary care provider, where she directed certain aspects of the nurses' clinical practices.

Bridget, a nurse participant, described how she worked with midwives to support clients who may be facing challenges with breastfeeding. The communication was ongoing, beginning when Bridget and a midwife worked together to develop a plan for discharge and follow-up.

And as well, as far as breastfeeding, midwives are trained in supporting moms with breastfeeding. But sometimes the midwives feel a little perplexed, sometimes with breastfeeding issues and they call on us and, and we work together and make a plan for that Mom. And what's a plan for discharge and follow up. And sometimes they'll see the mom in their homes afterwards and report back and say 'so this is what's going on, this is what we're thinking, what do you think?' And we just chat about the patient, informally, in the hallway sometimes, and we just work together like that. (Bridget, Nurse)

Bridget believed that sometimes the midwives needed her support and expertise, particularly with breastfeeding, and she valued her informal communication with the midwives. The power

relations between the midwives and Bridget were fluid, where the midwives were primarily responsible for the client's care, but where Bridget's knowledge and expertise with breastfeeding support also positioned her as an expert. Bridget and the midwives she worked with were aligned with a discourse of collaboration. In a collaboration discourse, people work together in trusting relationships to share their expertise in order to meet shared goals for a mutually agreed upon outcome. Bridget valued the communication she had with midwives, where she could share her expertise, and where the midwives provided her updates and willingly asked for clinical opinions. Bridget was positioned as a nurse with expertise in breastfeeding support. The ongoing formal and informal communication between Bridget and the midwives about clients, illustrated their commitment to collaboration.

Participants did not often talk about the role of communication as a way to address conflict, however Susan shared her observation of how communication was initiated as a tool to address a disagreement between a nurse and a midwife at a hospital birth,

So in a situation once, the nurse questioned what happened in the room, and the midwife could pick up on, that the nurse might have questioned that. And they had an open discussion before the midwife left the care area. So I think that's wonderful, like nobody has to run to a manager to make things come together and talk. They had open conversation together, because their relationship was important to both of them. And that was made so clear to me from both parties.... To see the changes over the decades it's just been a pleasure, and inspiring that that can happen at that level with two people, two professionals and both walk away from it with a clearer understanding of each other's perspective. (Susan, Stakeholder)

Susan valued the ability of health care professionals to resolve their own conflicts. She believed that the nurse and the midwife were able to resolve their conflict because their relationship was important to both of them. In large workplace institutions such as hospitals or large companies which employ many people, there is often an institutional discourse, which influences how employee conflicts are addressed. In this institutional discourse, institutional management is often responsible for conflict resolution between employees. For example, representatives of the institution, such as managers or human resource personnel, would meet with co-workers to resolve conflicts. In this institutional discourse, hierarchy and formality are valued and believed to be necessary for the resolution of conflicts and maintenance of a harmonious workplace for employees. In a person-centered care discourse, relationships between the people involved in a client's care are valued, and the responsibility for maintaining relationships depends on the individuals themselves. Therefore, in a person-centered care discourse, co-workers who have a conflict are encouraged to resolve it themselves. In working out the disagreement themselves, the midwife and nurse communicated directly with each other to resolve the conflict, and challenge the institutional discourse that held the belief that the institution needed to mediate it. The midwife and nurse aligned themselves with a person-centered care discourse and shared responsibility for the resolution of their conflict. Susan's reaction to the nurse's and midwife's approach to conflict resolution was one of inspiration because she was used to conflict resolution that relied on hierarchical intervention from the hospital institution. For Susan, the actions of the midwife and the nurse challenged the institutional discourse of conflict resolution, and this was a challenge that Susan welcomed.

Participants discussed how the mode of communication in the context of how midwives and nurses collaborate, was often verbal. A few participants believed that non-verbal

communication and communication with little verbal detail was integral to their practice.

Annabelle, a midwife participant, talked about how she had to 'say one little thing' and the nurses knew what she meant, and were able to anticipate her needs and the clients' needs.

One of the things here for sure that is really stood out is just how quickly and how well, they can anticipate, what I'm going to be needing.... And here, I've just been always really impressed whenever they can, I'm like okay, I just have to say one little thing and instantly they they're on board and they know exactly like.. When I call the hospital, once I had a woman coming in and I know she was flying and I was like, 'she's coming in and I think it's going really quickly', they were at the door, waiting for her to get there. I'm like 'she might get there before I do', that they were ready, they had their bag they had their stuff ready to meet her at the door. They didn't need me to explain things in great detail, like on it, you know and I know for the women too in that situation they really appreciate that. (Annabelle, Midwife)

Annabelle valued how the nurses anticipated what she needed and the needs of her clients. She also valued how communication, non-verbally or using few details, yielded appropriate anticipation and timely support from the nurses.

But you know if I'm anticipating a shoulder dystocia, I just have to kind of look at them and be like and they're like okay, on it. You know they're just really quick and really yeah, they're really good anticipating.... Really secure, really great. Yeah, really safe, I really yeah. I trust them completely. (Annabelle, Midwife)

Annabelle believed she could use non-verbal communication with nurses in a serious birthing situation because she trusted that the nurses would know what to do. The nurses' abilities to quickly anticipate her needs and the needs of the client made her feel safe. In a medical

discourse, direct and clear communication is valued and believed to be an important aspect in the delivery of safe and efficient care. In a midwifery discourse, clear and verbal communication was valued, as well as more nuanced modes of communication that include non-verbal communicative strategies. Annabelle aligned herself with a midwifery discourse and she valued the nurses' capacity to understand and respond to non-verbal communication or communication with few details. Annabelle's practices of communicating non-verbally or with little detail challenged the hegemonic medical discourse of communication in which clear verbal and detailed communication is valued. The nurse's practices of anticipating Annabelle or the client's needs based on non-verbal communication, or little detail in verbal communication, reinforced Annabelle's trust in them.

### **Summary**

Midwives and nurses in Nova Scotia negotiate their roles and practices with one another at an individual level, and at each birth where they work together. When nurses and midwives worked together, there was a great deal of flexibility in how they negotiated clinical assessments, clinical tasks, and supportive care. The flexibility to accommodate the needs of all the members of the birthing team, including clients and their families often reflected a discourse of person-centered care. Participants also valued the crossover of their practices and skills, and how this meant that they were often positioned to provide person-centered care. Communication was an ongoing process between midwives and nurses and occurred both formally and informally between providers and with clients. Midwives and nurses valued their abilities to communicate effectively with one another, even if that meant it was non-verbal or with little detail.

## **5.2 Sustaining relationships: ‘The more we can just build relationships with one another’**

In this theme I present how midwives and nurses sustain their relationships with one another when they collaborate in Nova Scotia. Nearly all of the participants talked about different aspects of relationships between midwives and nurses. The theme, sustaining relationships reflects the ways that midwives and nurses; experienced trust, dependency and spending time together. The sub-themes that contribute to this main theme are; 1) Testing trust, ‘If they did not trust us, they would not sign up’ 2) Depending on nurses, ‘we could not do our job without them’ 3) Needing more opportunities together, ‘they are not the unknown anymore’. I will present each of the sub-themes in more detail below.

### **5.2.1 Testing trust, ‘if they did not trust us, they would not sign up.’**

Several participants in the study talked about trust in the context of how midwives and nurses work together in Nova Scotia. These participants talked about; their experiences building trust, understanding that trust is experienced individually between each midwife and nurse, and how the visibility of trust between nurses and midwives can impact a client’s birthing experience. Trust appeared to be particularly important in the context of RN Second Attendants.

A nurse participant talked about how trust was built between a midwife and herself over time. Eve explained that it took time for her to trust the midwives. Initially she was not familiar with the training or background of midwives, and she relied on her observations and experiences working with midwives to inform her ability to trust them,

So a lot of that I didn't know until I kind of learned it through the grapevine and asked questions, and then over time watched their approach and the care that they gave their clients, and learned to trust a little more, because again when you're not familiar with the background or the training that someone receives then you don't know what their

approach is going to be, and you wonder if they're going to recognize things in time that would prevent or avoid a certain consequence. So I think I was afraid to trust what they'd be able to do in an emergency. And working with them now closely I have much more confidence in their abilities and then in my own to support them I guess. (Eve, Nurse)

Eve was positioned as a nurse within an established health care system. She questioned how midwives practiced as she compared their practices to her own practices. She worried that the midwives would not know what to do in an emergency situation. Eve believed that midwives worked differently, and this awareness illustrated her knowledge of a different discourse of birthing from the one that she identified with. Eve was socialized professionally within a medical discourse about birthing. Her introduction to midwives and a midwifery discourse of birthing, challenged her professional socialization to childbirth. This was evident in her initial hesitation or fear to trust midwives. In her professional exposure to a medical discourse of birthing, the expertise and education of midwives, and their ability to provide safe perinatal care was not included, which led to her questions about the practices of midwives. Eve wanted to understand what was similar and different between her practices and the practices of the midwives, so she asked questions, observed how the midwives practiced, and worked with midwives. Eve's experiences ultimately led her to trust that the midwives' practices were safe and effective. Her confidence in her own abilities to support the midwives illustrated the trust she developed for the practices of midwives.

Florence, a midwife participant talked about how trust existed between midwives and nurses individually. Overall, Florence felt that the trust between nurses and midwives was 'incredible' but she also talked about how trust between midwives and nurses varied because everyone was different. She recognized that there were likely nurses who were less trusting of

some midwives, and midwives who were less trusting of some nurses. The differences in how she trusted certain nurses influenced how she practiced in a hospital,

Oh, incredible. Yeah, incredible trust. Yeah, definitely. And everyone's different, I know that there are probably nurses that work in the birthing unit that maybe aren't as trusting of us or some of us and not all of us and vice versa. There are some nurses that I work with that I know I need to race to get there because she won't even do a blood pressure before she's doing a vaginal exam on one of my clients, and I'm like - that's not necessary, right? And then other times it's like, ugh, whatever, like there are times to a degree in order to have the collaboration that we have you have to be prepared to let go of a little bit of control. And that's something midwives are not good at. (Florence, Midwife)

Florence adapted the way that she practiced in situations where she did not trust a nurse to provide a clinical assessment in a way that was congruent with her approach. When practicing within a midwifery discourse, a midwife or care provider is trusting of birth as a normal process that does not require a lot of invasive assessments or interventions when the birth is considered low-risk and progressing without complications. When practicing within a medical discourse of birth, providers are motivated to conduct clinical assessments with immediacy, such as vaginal examinations, to determine the progress of a patient in labour. It is often difficult for providers practicing within a medical discourse to trust the course of labour without first doing a vaginal examination as a means for establishing a baseline for comparison of future results of clinical assessments. Florence recognized that there were certain nurses who worked within a medical discourse of birth and were likely to perform vaginal exams as soon as a client arrived at the hospital, even though it was a midwifery client. In an attempt to minimize this practice with her

midwifery clients, Florence made an effort to get to the hospital as quickly as she could when she worked with certain nurses. In these situations the nurses worked within a medical discourse where vaginal examinations during labour were valued as important, timely, clinical assessments of labouring women. This was different from the midwifery discourse in which Florence worked where she valued limitations on invasive clinical assessments, such as vaginal examinations, and she trusted an uninterrupted process of birth. Florence's practice of rushing to the hospital to protect her clients from vaginal exams that were 'not necessary' was determined by her trust in the particular nurse she worked with, and whether that nurse's practices aligned with a midwifery discourse or medical discourse of birth. She also recognized that there were other times where she used her agency to relinquish control in her position as a primary care provider in order to maintain a collaborative relationship with a nurse. Florence valued the collaboration and trust that happened between midwives and nurses at her institution and she tried to maintain collaborative harmony. She negotiated this relation of power by choosing to let go of control. In the circumstances when she chose not to assert her authority as a primary care provider in order to minimize the practices of a nurse, she resisted against the option to assume her place in the medical hierarchy in favour of collaboration.

Annabelle, another midwife participant talked about how the visibility of her trust in nurses influenced the birth experiences of clients. For this participant, clients had communicated to her how seeing her trusting relationship with the nurses during hospital births reinforced their ability to trust the nurses.

Yeah, I have had a couple. I'm not going to say where it was. But of women who may have had a midwife previously and they felt that they didn't trust the nurses, but this time they felt safer in the hospital and that their opinions were like helpful opinions because

they weren't getting an 'us versus them' reaction. So like the midwives versus nurse and they felt you know after they had the baby, the second time with me they said you know staying in the hospital afterwards, it felt much more positive because I felt like you know the nurses were actually trying to help, they weren't the enemy or they weren't trying to tell me information that wasn't correct. Because I saw that you trusted the nurses, so I trusted the nurses and I heard that from a few clients. And I have also heard women say you know the nurse overnight she really reiterated a lot of things that you said and that was really helpful that I saw that you were both on the same page or when they asked like 'what do you think about this this or this?' and I'm like 'oh yeah, who told you that?

That's great information.' (Annabelle, Midwife)

Annabelle believed that some of her clients had prior birth experiences where there were feelings of 'us versus them' between the nurse and midwife, which resulted in the clients' distrust of nurses. Annabelle valued how the visibility of trust between herself and the nurses she had worked with had helped to challenge some of her clients' dichotomized thinking of nursing (aligned with medicine) and midwifery. Annabelle's trust for the nurses was visible to her clients and this promoted collaboration between the providers, and illustrated a commitment to working within a person-centered care discourse for all clients, regardless of their primary health care provider. Midwifery discourses have reflected beliefs and values of birthing care as holistic, supportive and personal, where midwives provide continuity of care. This is different from a medical discourse of birth which has reflected beliefs of birth as; an institutionalized event, needing to be managed, and where women receive care from providers they may have never met before. Client experiences of trust between midwives and nurses, helped to re-orient or create a

new understanding about the shared goals of nursing and midwifery when it came to their perinatal care.

Colin, a midwife participant, talked about how trust is integral for nurses who seek opportunities to be RN Second Attendants at home births with midwives who are the primary providers.

But in order to have some kind of off call life we need the nurses to come, and so we have a team of them that we can put on a roster but it's incomplete. We don't have enough to have a hundred percent coverage, so we have missed a couple of home births because we didn't have anybody. So we need more...Right now [several], and when we have more midwives that will help too because then we can also fill in without having to be a hundred percent on call. So that's coming. I think that I'm really happy like that they've been keen to step up and do that, and that's a huge sign of trust that the nurses would do that. If they didn't trust us they would not sign up to be at home doing births with us...

(Colin, Midwife)

Colin believed that the nurses' willingness to be RN Second Attendants for home births illustrated the nurses' trust of the midwives. She valued having nurses who can be RN Second Attendants for home births because it helped the midwives have some time to be off-call and to have some work/life balance. Choice of birthplace is an integral part of a midwifery discourse. In fact, one of the Canadian midwifery standards asserts that midwifery clients have the right to choose where they want to birth. In Nova Scotia, home as a location to give birth was introduced as a health system supported option after the regulation of midwives. Prior to this, the only choice for birth place, endorsed by the health system, was in the hospital. Hospital as the 'safest' choice for birth is part of a medical discourse which was challenged by midwives and midwifery

clients when midwives were integrated into the health system. Colin and the RN Second Attendants were aligned with a midwifery discourse about the choice of birth place location and they wanted to ensure that home birth services were available to their community. Colin was grateful for the nurses who were ‘keen to step up’ and become RN Second Attendants for home births. The RN Second Attendants positioned themselves to support the midwives and the choice of birthplace, however their support was still not enough to be able to offer home birth services at all times. For Colin, the trust that nurses had for midwives, influenced their use of agency to become RN Second Attendants. She was conflicted however, because without more institutional support, in the form of hiring more midwives and more RN Second Attendants, home birth services will not be an option available at all times. In this situation the trust between the midwives and nurses, that has influenced nurses to become RN Second Attendants, is not enough to ensure consistent delivery of home birth services, the hospital institution maintains power through the staffing decisions to determine the sustainability of home birth services.

### **5.2.2 Midwives depending on nurses, ‘we could not do our job without them.’**

Some midwife participants talked about how they depended on nurses to deliver midwifery services at their respective sites in Nova Scotia. The creation of the RN Second Attendant role for home births was identified as a way for midwives to be able to provide a choice of birthplace to clients. In particular, participants talked about how integral RN Second Attendants were to the sustainability of home birth services. Midwife participants talked about how important the nurses’ support was for both hospital and home births. One midwife participant talked about how she would not be able to do her job, the way that she does it, without help from the nurses. It appeared that the nurses were valued by the midwives for their contributions to, and support of, midwifery and midwifery services.

Depending on nurses was structurally embedded in Nova Scotia due to the implementation of the RN Second Attendant program. Janet, a stakeholder participant talked about how the RN Second Attendant program was created to 'increase the availability of home births' in Nova Scotia.

It was initiated to, I believe, to increase the availability for home births. So as I commented there was a team of two midwives and if both midwives are up all night because 75% of births happen outside office times, it's, invariably, that is in the middle of the night. So both midwives are up all night supporting the delivery, and then there's nobody to do their clinics or whatever they have scheduled for the next day. So I believe the second attendant program came out as a result of the Kaufman Report in 2011, and this was to support home deliveries so that one midwife could be there with a nurse who had had additional training to be able to do that. And then that still meant that the midwife who wasn't on call was still fresh and able to do clinics or home visits or whatever the following day. (Janet, Stakeholder)

Janet believed that nurses as second attendants for home births were introduced to ensure that midwives had more balance with their on-call schedule for home births. In a medical discourse a hospital is the location for birth. Individuals who are aligned with a medical discourse take for granted the staff who are present in the physical institution of the hospital to meet any eventuality at any time. In a medical discourse where the hospital is the location for birth, nurses, as staff of the institution are positioned to respond to the unpredictability of birth because they are physically present within the institution at all times. In a midwifery discourse, where home is an alternative birth place option, midwives (the only primary care providers who provided planned home birth services in Nova Scotia) must be available or on-call for the unpredictability

of home and hospital births at all times. Midwives must always be flexible for any potential birth that may occur, a huge demand when midwives are understaffed. There was a shortage of midwives in Nova Scotia and this staffing challenge was consistent with a global discourse around a shortage of midwives worldwide. Prior to the RN Second Attendant, midwives did not have the same institutional back-up for home births that they did for hospital births where nurses were always present. Janet valued the work of midwives that occurred outside of 'office times.' She recognized the need to support home birth and she saw the tension created by having midwives who were always on call for home births and the challenges they faced when home births impacted the work that took place during their 'office time.' She believed that the introduction of the RN Second Attendants was an institutional effort to acknowledge and support home birth services in a space (home) that does not have access to continuous nursing staff. Through the introduction of nurses as RN Second Attendants for home births, institutional decision-makers extended midwives' dependency on nurses from the hospital institution to the home environment. This extension of dependence illustrates how the hegemonic medical discourse of hospital birth continues to inform and influence midwifery practices. Although the RN Second Attendant program has helped sustain home birth services at the three model sites, it still does not address a systemic shortage of midwives and home birth services throughout Nova Scotia.

Florence, a midwife participant, talked about how home birth as an option for a birth place would not be available to clients without the support of RN Second Attendants. For Florence, the introduction of RN Second Attendants made home birth more accessible to midwifery clients because there were more health care providers to share on-call responsibilities,

It hasn't changed our on-call, because we still have two midwives on-call. But if there's two midwives on-call and a second attendant and there's a home birth going on, then that second midwife knows she's probably off the hook. So while it hasn't reduced our on-call time it has reduced the number of times when we're on-call to have to get called out to a home birth. And then on top of that it's salvaged home births, and what I mean by that is if there's two births at the same time and one's a home and one's a hospital then the one midwife could be at each birth and then the second attendant will make sure that the home birth can take place. Because in the past without that we would have actually been calling around to the midwives that were off call to see if somebody would be willing to come back on to ensure that home birth could take place. And that's more about the woman than it is about us, it's more about giving the woman what she wants, because if everything is healthy and low risk and normal having to transfer into the hospital just because we don't have somebody seems a big shame, right? (Florence, Midwife)

For Florence, the inclusion of RN Second Attendants ensured that women were able to birth in their place of choice. She believed that women who meet the criteria for a home birth should not have to transfer to a hospital because of staffing shortages. Florence valued RN Second Attendants for home births, and she believed that this new role for nurses has 'salvaged home births'. In other words, the midwives would not be able to provide consistent access to home birth services if nurses did not support home birth as Second Attendants. Like Janet, Florence believed that the inclusion of RN Second Attendants had improved the availability of home births services for clients. Florence positioned herself within the midwifery discourse that upholds a birthing person's choice of birth place. She accepted the support of nurses and how

midwives were positioned to depend on nurses in order to ensure that her belief in the choice of birth place was an option to birthing. Florence aligned herself with a choice of birth discourse and was willing to work with nurses, in order to preserve home birth as an option to clients and their families. Midwives depended on nurses, who were positioned as RN Second Attendants, to support midwifery practices and the sustainability of home births services. This dependence on nurses also extended the historically gendered discourse of nurses as helpmates for primary health care providers to new perinatal contexts outside of the institutional setting of the hospital.

For Annabelle, another midwife participant, her dependence on the nurses was not limited to RN Second Attendants at home births, but also included the nurses she worked with in the hospital. Within the hospital institution, the nurses were present as 'back-up' for every hospital birth and they helped Annabelle with many institutional and labour related tasks,

So the biggest thing here is working with the nurses on the floor, they back us up for our births. And they also if we're transferring care if they're involved with any of our clients, you know they're always so good to help us out in any way, shape, or form. So if I have someone coming in, you know I'm like 'okay they're going to be here before I'm here.

Can you get them settled in, give me a call if it sounds super urgent, I'll be there as soon as I can.' Helping me get things ready for a precipitous delivery they can do all that stuff.

Get them registered or if I have two women in labour at one time, they can kind of labour sit one of them and help and do that while I'm with the other one. So they've been really great to work with. Just in general, they're awesome and they do back us up at every

birth... (Annabelle, Midwife)

Annabelle depended on the nurses during hospital births. She valued the ways that the nurses assisted her with clients, and she depended on their clinical and administrative support.

Interestingly, Annabelle seemed to value the hegemonic medical discourse which historically positioned nurses as help mates to primary care providers. She also believed that she could depend on the nurses because they were always available to help during hospital births.

Annabelle also relied on nurses who are Second Attendants at home births:

And the other part of it is that we have a few nurses that are second attendants for a home birth. So whenever we have our women interested in home birth, we can rely on them whenever they're available: it's always the busiest nurses that want to be second attendants, of course. So we have [several] nurses that we use for second attendants, they've been amazing and they're always very keen to like help us out whenever they can.

(Annabelle, Midwife)

Annabelle's experiences of depending on nurses occurred at both hospital and home births. In a medical discourse, nurses are skilled health professionals who support primary health care providers by notifying them of any changes in patient status based on a nurse's ongoing monitoring and assessment of patients. In this discourse, primary health care providers can depend on nurses for their assistance in the clinical assessment and care of patients which reinforces the historically gendered positioning of nurses as helpmates, replacing physicians with midwives as the primary care providers that require support. Annabelle accepted the nursing discourse where nurses were positioned as health care professionals who could assist and support primary health care providers. Annabelle's acceptance of this discourse was illustrated when she used her agency to choose to accept the nurses' help at hospital and at home births. The power relations between Annabelle and the nurses she worked with reflected complexity. Annabelle depended on nurses' clinical and administrative assistance at hospital and home births, and from this perspective nurses were positioned in a place of power, based on whether they aligned

themselves with the nursing discourse and positioned themselves to support midwives. However, once the nurses offered their assistance, Annabelle was then in a position to use her agency to decide whether and how she would accept their support. Tension did not appear to exist for Annabelle when she negotiated her relationships with nurses because she could easily depend on nurses at both hospital and home births.

Colin, a midwife participant, articulated her dependence on nurses in order to be able to do her job. For Colin, nurses were a normal part of providing care to clients and she believed that midwives and nurses at her hospital were a team,

Here they are a hundred percent integral, like a hundred percent. We could not do our job without them. So they do our backups here in the hospital... So every birth I see a nurse. I don't see them as much in the post-partum ... No, I do in terms of some connection with Public Health and lactation consultants. So I just feel like they are really ... instead of someone that we didn't really understand each other's roles and we only saw when things weren't going so great, here I see them with normal births, I see them at home births, I see them for breastfeeding issues after. They're just a normal everyday part of our delivery, and we are legit a team. (Colin, Midwife)

Colin believed that the nurses were integral to being able to do her job as a midwife and she valued the nurses' expertise and knowledge in terms of hospital births, home births, and breastfeeding support. Like Annabelle, she accepted the nursing discourse of nurses as skilled health care professionals who support primary care providers with their continuous presence, assessment skills, and care of patients. Colin's acceptance of this nursing discourse was illustrated by her belief that the midwives could not do their work as midwives without the support of the nurses. Colin recognized that her practices as a primary care provider depended on

the clinical support of nurses in her every day practices. Colin's dependence on nurses for daily and other aspects of clinical care meant that nurses had power to greatly influence her professional practices.

### **5.2.3 Needing more opportunities together, 'they are not the unknown anymore'**

Most participants in the study talked about the need for more professional and social opportunities between midwives and nurses. Participants talked about the importance of midwives and nurses having more time to know each other and to know each other's strengths and 'hidden talents. Participants recognized the benefits to their practice, and ultimately to their clients, of building relationships between midwives and nurses through the creation of more opportunities to work, socialize, and learn with one another.

Sunny, a doula participant, talked about the importance of getting to know other care providers. Sunny believed it was important for providers to get to know each other's' strengths and 'hidden talents' which could be used to positively impact a client's birth experience.

Yeah, I wish that there was more time that people could just get together and know each other in regular everyday settings. I wish everyone wasn't so pressed for time so that when there is a new Midwife on board or a new [DOCTOR] or a new nurse everyone could just ... even if they had one brief conversation that goes a long way. We're not all going to remember each other's names but we're pretty good at remembering faces, and just getting a sense for that person and what they might have on offer that's special about them, because we all have hidden talents and they can shine at birth setting, and if we know to draw upon them then that's to the benefit of everybody. (Sunny, Health Care Provider Colleague/Doula)

Sunny saw the benefit of building relationships with other care providers so that everyone involved in a birth could benefit from an individual's strengths. She recognized that time was not abundant for midwives and nurses, but she valued conversations between providers so that they could at least 'get a sense' of one another. As an example, Sunny described an experience where a midwife knew that a particular nurse was a singer and asked her to sing to a woman in labour as a means to provide comfort to a labouring client.

So for instance, there is a nurse who is a brilliant singer, and the midwife knew that this family was very musical. And the mom was having a hard time, and she kind of nudged and asked if the nurse would be comfortable seeing singing, which the nurse loved and wanted to do. But if they didn't know each other the Midwife wouldn't know to ask. So that was to everybody's benefit. So just these tiny little details can really make a remarkable difference for everybody when we know to draw on our talents. (Sunny, Health Care Provider Colleague/Doula)

Sunny was conflicted by the lack of time that health care providers had to get to know each other and her belief in the value of person-centered care. She was frustrated that health care providers did not have time together beyond the time they spent providing care to women. She believed that everyone had hidden talents that could be beneficial to each other at births. Sunny experienced a conflict related to an institutional discourse associated with a hospital, where efficiency of care meant that the time care providers were together must be directed to patient care and not spent on activities considered of a social nature. For Sunny, this discourse was different from a discourse of person-centered care, where all individuals involved in a birth are valued members of that experience, and as such, building relationships between those individuals is very important for optimal birthing care. Sunny had an experience, where a midwife

positioned herself within a person-centered discourse because the midwife had developed a relationship with both the client and the nurse that she was working with. The midwife knew of the nurse's singing talents and the client's musical interests, and she used her agency to encourage the nurse to sing as a way to bring comfort to the client during her labour. The midwife's knowledge of the nurse's singing skill and the nurse's willingness to sing for the labouring client illustrate how both providers positioned themselves within a person-centered care discourse, where the client was centered in the care, and the relationships between the providers ensured a positive experience. The midwife and the nurse challenged the institutional discourse, associated with the hospital that focused on efficiency of care, with their own actions that were informed by a person-centered discourse which valued relationships. For Sunny, this exemplified the need for health care providers to have opportunities to get to know each other.

Elisabeth, a midwife participant, also talked about wanting more opportunities for midwives and nurses to work together. However, Elisabeth identified the challenge of creating more opportunities together when resources were so limited,

If you would have more midwives maybe and more opportunities for nurses to work with midwives. And I mean, I think you can do a lot, like you can do workshops together, you can do research together, like those things. But we just don't have any resources here, I don't see it is. I mean, a good thing is I know that one of our midwives is teaching with nursing students.... That would be one part, teaching just normal births. Yeah, and we have sometimes placements from nurses working with us, from nursing students. But it's not very often, and again our resources are so limited. (Elisabeth, Midwife)

Elisabeth valued opportunities for midwives and nurses to work together, however, she believed there were no resources to support such opportunities. Although Elisabeth does not describe what

she means when she said that she did not have any resources, she could be referring to money, time, and a need for more midwives in Nova Scotia. Within a hegemonic institutional discourse of the health care system, the need to be financially responsible is valued. This is interpreted as not wasting finances on anything that is not directly tied to patient care or cannot be tied to a measurable outcome. In this discourse, it is difficult to justify spending funds on activities for team building because the output of those activities is difficult to measure. In a discourse about inter-professional collaboration, an emphasis is placed on building collaborative teams of multiple professions who trust each other and work well together. In an inter-professional collaboration discourse, opportunities for care providers, from different professional background, to work, research, and play together are valued. Elisabeth aligned herself within a discourse of inter-professional collaboration. She wanted more opportunities but she was conflicted with the lack of resources to support these activities. She observed that despite the lack of resources, one midwife was doing some teaching with nursing students, but she recognized that this was not ideal without more resources to support this type of work. Decision makers who locate themselves within an institutional discourse of health human resources, which upholds financial restraint, are positioned to make decisions regarding the use of resources that could increase inter-professional opportunities between midwives and nurses.

Ina, a nurse participant, talked about her desire to have nurses and midwives work together outside of the hospital and to ensure that all nurses have an opportunity to work with midwives in the hospital on a regular basis. She believed that ensuring that nurses had opportunities to work with midwives would reduce any fear or negative thoughts about midwives that some nurses may have.

But like wouldn't it be great if nurses and midwives worked outside of the hospital together? Because it would be more interaction to be together and more trust, opportunities to build trust with each other. Yeah, I think that would be amazing. I wish there was more midwives and more home births happening and more second attendants being hired, that would be really great. Or like if you had to rotate through, like as a nurse working on the [birthing] unit you had to do like four of our shifts every ... or like two ... or shift every month was with you were on call for a second attendants, like you didn't have to come in a hospital, you're just on call. Wouldn't that be awesome? Because then you have to work, you have to engage with this person. Even if you don't like them, you don't trust them, you don't think they should be there, you still have to work with them at that one time. And then once you work with them they're not the unknown anymore, you're not scared of them. (Ina, Nurse)

Ina believed that exposing nurses to midwives, by ensuring that all nurses have an opportunity to work with midwives regularly, could be a way to build relationships and reduce any fear or negativity amongst the nurses about midwifery. Ina suggested building relationships and trust between midwives and nurses using existing institutional hospital structures, such as shift scheduling, to ensure that all nurses have an opportunity to work with midwives, and in turn to learn from the midwives about midwifery. Without another strategy for midwives and nurses to get to know each other, this suggestion reaffirmed an institutional discourse where the institutional structure of a hospital is managed like a factory, and nursing staff is replaceable, depending on the needs of the hospital institution. In this discourse, the needs of the hospital institution outweigh the needs of the individual nurse or midwife. A person-centered care discourse, centers relationships between all individuals involved in a client's care. In this

discourse, no one is replaceable in the sense that everyone's contributions, opinions, and experiences are valued, with particular focus on the client's needs. The client and the individuals involved in the care of the client outweigh the needs of the hospital institution. Ina's suggestion, to use institutional hospital structures to ensure that midwives and all nurses work together located her within an institutional governance discourse. Her suggestion challenged a person-centered care discourse because the providers involved in client care may not share the same philosophical perspectives about birth, and not including providers in the creation of ways to work with midwives reinforced hierarchical mechanisms of institutionalized governance. In Ina's suggestion, power was located within the hospital institution and with the decision makers of the health care institution who determine how midwives and nurses would work together.

Interestingly, this reinforces a paternalistic hierarchy of institutional decision-making, where the gendered implications of such decisions made for midwives and nurses as predominately female professions remain invisible to the hegemonic medical institution. In a person-centered care discourse, the midwives and nurses would create strategies about how they would work together.

Several participants talked about what contributed to building strong relationships between nurses, midwives, and other health care providers at their hospital institutions. For Bridget, a nurse participant, the expectation for providers to engage with the MORE OB program, in addition to opportunities to socialize together, either informally at work or outside of work really enhanced the relationships between all perinatal health team members.

I can tell you things that I think have strengthened it here, is the MORE OB program.

Learning together not just going to a Midwifery course or going to a course on nursing or going to a course on physician skills. It's we all sit down at the same classroom and we all learn the same stuff. I think that was huge for collaboration. And I think being in

the same facility, working closely in the same unit together makes a huge difference. I think that's a huge strength. And I think playing together, doing social things outside work. Like not just a tea in the tea room, but like let's have a staff party, so and so's retiring. They come. You know. We plan a lot of social events. I think those things are important, they may not be professional things always, but I think they are important in making everyone, you know making our bonds strong, our relationship strong, professionally too. (Bridget, Nurse)

Bridget valued her relationships with the midwives and other care providers, and she believed that learning together and socializing together strengthened professional 'bonds.' Individuals who assume a discourse of inter-professional collaboration in health care, believe that when the health care providers work well together client outcomes are improved. In a discourse of inter-professional collaboration all members of the care team, who are from different professional backgrounds, are valued for their professional expertise and contributions. Trust is a key element of inter-professional collaboration, and this is built over time as providers get to know one another. Bridget aligned herself with a discourse of inter-professional collaboration because she wanted to strengthen professional relationships between midwives and other care providers. The decision makers at the hospital where she worked supported her interest in more opportunities for nurses, midwives, and other care providers to work together, particularly through the use of the MORE OB program. For Bridget, the midwives, and other perinatal care providers she worked with, opportunities to get to know each other and strengthen relationships were not limited to formal opportunities organized by the health care institution. The health care providers organized events and opportunities to strengthen their professional relationships socially, outside of the institutional space of the hospital. Bridget and her health care provider colleagues extended

the discourse of inter-professional collaboration beyond the institutional environment, because they valued their professional relationships with each other and used their collective agency to initiate opportunities themselves that would enhance those relationships.

Daisy, a nurse participant, talked about the importance of building relationships with each other. Similar to Bridget, Daisy believed that social and professional opportunities for nurses and midwives to work and spend time together improved collaboration.

I mean, having better working relationships too, like and our midwives like at our Christmas party, birthing unit Christmas party, they showed up. Like they, I think doing things outside like to build relationships and see who these people are. They're just like us. They're kind of just like a nurse; they just are helping deliver babies. And I think the more we can just build relationships with one another even... As a second attendant they invited us to go do NRP, like I'd already done mine, but they invite us to do NRP with them... Yeah, like why not? Sure, like next time I will do it, I'll make a point of doing my NRP training with them because we do have a little bit, we have a relationship but we also have a different scenario if we're out together doing a delivery versus in the hospital with a NICU next to us that can come to the delivery. (Daisy, Nurse)

Daisy valued formal and informal opportunities to build relationships with midwives. She believed midwives were kind of like nurses, but they delivered the babies too. She positioned herself as a nurse and saw the similarities between midwives and nurses. Getting to know the midwives, formally and informally, may be important in a larger context of understanding who a midwife is and how the similarities and differences between midwives and nurses are reflected personally as well as professionally. Daisy used her agency to decide that the next time she recertified her NRP, she would do so with the midwives because of her role as an RN Second

Attendant at home births. As an RN Second Attendant for home births, Daisy wanted to ensure that she had opportunities to practice scenarios during NRP recertification's, because of the differences in available resources for emergencies at a home birth compared to hospital births. Similar to Bridget and other participants, Daisy accepted a discourse of inter-professional collaboration which reflected her value of more opportunities, socially and professionally, to strengthen the collaboration between midwives and nurses where she worked.

### **Summary**

In Nova Scotia, midwives and nurses work to sustain their relationships individual and professionally. The ways that nurses and midwives sustained their relationships was illustrated in the three sub-themes identified within this theme. Trusting relationships between midwives and nurses were valued by participants as a foundation for collaborating in different contexts, whether it was for hospital or home births. Participants also identified how midwives depended on nurses for their support in the delivery of midwifery services in the hospital and in the home, as well as their support of the midwifery profession. Interestingly, participants did not talk about nurses depending on midwives for their practices or the sustainability of the nursing profession. Midwives depended on nurses from a larger systemic profession, in order to provide midwifery services within a medical model of care. Participants also expressed their interest in more formal and informal opportunities for midwives and nurses to collaborate and strengthen their professional relationships.

### **5.3 Reconciling Systemic Tensions: The Medical Model and the Midwifery Model**

All of the participants discussed how midwives and nurses in Nova Scotia navigate systemic tensions between the midwifery model and the medical model. A number of tensions were identified related to; 1) The (in)visibility of collaboration and 'the best kept secret' 2)

Resisting and accepting institutional expectations 3) The “medical approach versus the midwifery approach.” Each of the sub-themes will be presented in more detail below.

### **5.3.1 The (in)visibility of collaboration and ‘the best kept secret’**

Most of the participants in the study talked about the (in)visibility of how midwives and nurses collaborated in Nova Scotia. Participants discussed the (in)visibility of contributions that a nurse or midwife made in their professional roles, the ways that midwives are subject to surveillance by colleagues, and learning through watching the practices of each other. How collaboration between midwives and nurses was (in)visible varied, and the reactions that midwives and nurses had to their (in)visible practices of collaboration were also mixed.

Emma, a service user participant, whose hospital birth was attended by a midwife and a nurse, the practices of the midwife were clear. Although she was unsure what to expect in terms of the ‘dynamic’ between the midwife and the nurse, she understood that the midwife would be the primary care provider and that a nurse would be present.

I would say I'm not sure what I expected actually. Yeah, I'm trying to recall if they had mentioned that they would be ... that the midwives would be there but the nurses maybe she did mention it. I wasn't really sure what to expect in terms of that whole dynamic, but I did know that the midwives would kind of be running the show and kind of taking care of everything. Yeah, I'm not really sure about the ... I don't know, this is going to sound horrible but like what the role of the nurse would be in that situation because I felt like the midwife, like she only has like two hands but I felt like she was very much attentive to kind of my physical needs as well as like my mental and emotional needs. Yeah, so she was helping me through kind of like the whole labour in the process, but she was also kind of very much aware of what was going on with my mind and still talking to me and

still being very encouraging. So I'm not saying ... I don't want to say like the nurses are almost invisible, but they were there just ... just kind of at a distance, even though they were close to me it just felt like their care I didn't really feel it impacting me that much.

(Emma, Service User/Mother)

Emma valued the midwife's attentiveness to her physical, mental, and emotional needs throughout her labour. Although she recognized that the nurse was physically present during her labour, she believed that the nurse's care didn't really impact her. Emma was conflicted about her understanding of the nurse's contributions to her birthing care, she didn't want to share her observation that the nurses seemed invisible. She questioned the nurse's role at her hospital birth, because she believed that the midwife attended to all aspects of her care. In a nursing discourse of birthing care, nurses are present during labour and delivery, they provide constant supportive and clinical care until the physician arrives for the delivery. In a midwifery discourse, the midwife is present throughout the labour and delivery and provides constant supportive and clinical care, and then the midwife catches the baby. Having chosen a midwife as her primary care provider, Emma was aligned with a midwifery discourse of birthing care and expected that the midwife would support her clinically and supportively. The nurse was not as visible to Emma because the midwife provided the majority of the clinical care and labour support. Emma did not understand what the nurses did at births with midwives, when the midwives attend to all of the client's needs.

Florence, a midwife participant, talked about how midwives and nurses relieved the burden of care for each other when they collaborated at hospital births. She noted that this was particularly the case when a client had an epidural, and required supportive labour care.

To be honest I would be probably tarred and feathered in a room of midwives to say it, but I like hospital births just as much as home births... Because I get to go to the hospital and see all these people that I love chatting with, and that are really good people, and they make my job easier, and I make theirs easier. Because the best-kept secret, and we all chat about it, is that when you have a birth and a nurse and a midwife in the room at the hospital it's easy, because we clean up with them, like we're all doing the same ... There's so much overlap in our roles that we're taking a huge burden off of them with a client that isn't epiduralized usually and would be a lot of work, and then they're taking off a huge burden for us. (Florence, Midwife)

Florence valued hospital births and the opportunities to work with nurses. Florence believed there was an overlap in the roles of the midwives and the nurses and she believed that this made it easier to provide care to clients. Florence also believed that midwives working with nurses at the hospital was a 'best-kept secret,' because of the overlap of roles and sharing of tasks, although the secret was known and discussed among midwives and nurses. The midwives and nurses chose to protect their collaborative practices by maintaining the 'best-kept secret' of birthing care in hospital. In an institutional discourse of the delivery of health care services, efficiency of care delivery is valued, and decision makers are guided to make decisions about the allocation of physical and human resources in hospital institutions based on efficiency, and the reduction of redundancy. Florence valued the crossover of skills and the inter-professional collaboration between herself and the nurses in the hospital. Florence and the other midwives and nurses used their collective agency to protect their collaborative practices from decision makers, aligned with an institutional discourse of the hospital, who may view the overlaps in

their clinical care as inefficiencies and then question or change the ways that midwives and nurses worked together in the hospital.

Colin, another midwife participant believed that her work as a midwife and the whole picture of what she did as a midwife, was not visible to her nursing and health care provider colleagues. She valued her role as a midwife but wanted nurses and health care provider colleagues to understand that, although she shared many skills with both professions, she was not there to replace them.

And that is not a nursing fault it's just a workload issue and the fact that they have a lot on their plate and we're all in a hospital that is small trying to do too much with too many people. So sometimes I feel like midwifery is viewed as, well, you don't need help because you're the midwife, you can do it all. And it's like we're trying, like we're not here to do the work of the nurses, we're not here to do the work of the OB. We're here to work alongside and be part of the team but not of instead of, that's where we run into trouble....That is the lonely part of the job... It is, because it's not deliberate it's just incidental, it's just because of the system here. But when you are trying to manage all of this by yourself and they don't know that I had no sleep or that I have a home visit or that I have a full day of clinic or that I was here for 19 hours because they just came on call. It's really sometimes I feel like the truth of our job is really invisible, they see parts of it but they don't see the whole thing especially when you're working alone. And that kind of sort of lonely misunderstood aspect is the part that I think burns you out and makes you want to leave. (Colin, Midwife)

Colin believed that the invisibility of what she did as a midwife was incidental and 'not deliberate' within the health care system. Her invisibility also led to her feelings of being

misunderstood and lonely. In a midwifery discourse, midwives are independent and autonomous health care professionals who are capable of providing perinatal care throughout the course of the perinatal period. Historically, the work of midwives was invisible to the health care system due its exclusion and marginalization from that system, and the gendered nature of midwifery work, where 'women's' work has been traditionally undervalued and not formally recognized. In an institutional discourse of health care, nurses and physicians work together in a hospital, particularly during labour, birth, and the immediate postpartum period. The roles of nurses and physicians have been integrated into the institutional framework for collaboration in health care. Colin was conflicted by the discourse of autonomous midwifery and her lack of integration into the health care 'system' as a team member. Although she was positioned as an autonomous midwife, she also valued the institutional discourse, in health care, of integration with other health care providers. Colin disrupted the discourse of autonomous midwifery because she articulated her desire to be, visible, integrated, understood, and supported as a member of the health care team within the 'system'.

Participants also talked about the ways in which they observed each other's practices and the visibility of those practices. Participants were aware of how midwives and nurses practiced, either through their own observations or through the observations of others. Ina, a nurse participant, was inspired by the conscientious practices of midwives.

The midwives here are very good at following everything to the book, because I think they feel very ... like they're under constant surveillance of their actions, because people are just so quick to be like - you see that's because you had a midwife. So watching them, it's just, it's really inspiring that they're able to walk that line of like ... Just their strength, their sheer strength I think to be able to consult with the person that is really intimidating,

that they know doesn't want them part of the system. I think they're incredible role models in that way. And their own conflict of like how they would like to practice versus how they have to practice, and just knowing how to navigate that is ... (Ina, Nurse)

Ina believed that the midwives felt like they were 'under constant surveillance' and as a result the midwives were very conscientious in terms of how they practiced and cared for clients. She was inspired by how the midwives were able to reconcile the differences in how they wanted to practice with how they practiced when they were under surveillance. In a discourse of professional distrust, professionals may not understand each other's roles or share a working goal, and as a result, the activities and practices of professionals may be observed and monitored closely. Gender likely played a role in professional distrust which led to the surveillance of midwives, who are a female dominated profession and newly integrated into the health care system, and who may have been perceived as a threat to other health care providers. Ina believed that the midwives were practicing within a discourse of professional distrust for midwives. She believed that the midwives were constrained by the surveillance of their actions, however in order to prove their trustworthiness, they changed their practices to ensure their practices complied with expectations of other primary care providers in perinatal health care.

Daisy, a nurse participant also described an experience of surveillance at a hospital birth, where a nursing colleague was informed by the charge nurse to be the 'eyes and ears' for what was happening while a midwife provided birthing care to a client. In Daisy's experience, it was a charge nurse who expected another nurse to surveil and then report back what happened during the birth.

I find that people do really work well with the midwives. There's still some ... I'm going to say this, someone, a charge nurse one day, it really bothered me and it bothered the

nurse that she said it to who was also a second attendant, said 'you go in that room,' like she ... it was ... she said, one of the other nurses who's a second attendant and that she says 'eyes and ears, eyes and ears'. She said of the midwifery patient eyes and ears, as in like what do you want us ... like this is a professional in there with that patient, and they're providing, why are you saying we need to be watching what they're doing? Like that, is a charge nurse that is doing that. That bugged us when we talked about that later... Furious. But there is still that element of people that say ... I don't know if it's like a mistrust, unfamiliarity, how many times does a charge nurse do delivery with a midwife? Never, right? (Daisy, Nurse)

Daisy valued midwives as professionals who provide birthing care to clients and their families. She believed that the charge nurse wanted another nurse to watch how the midwife practiced and provided care. Historically, there has been a medical discourse about midwifery in which midwives were considered untrained, unclean, unsafe, unprofessional, and worked outside of the health care system. Since the regulation of midwives in Canada, an alternative discourse of midwifery has been constructed, where midwives should be valued as educated, safe, clean, professional, and included primary care providers within the health care system. In Daisy's experience, the charge nurse aligned herself with a medical discourse of midwifery. Daisy aligned herself with an alternative discourse of midwifery and she questioned what the charge nurse told the other nurse to do. She believed that the practices of a midwife were invisible to the charge nurse, who does not usually attend births with midwives, and wondered if the charge nurse's inexperience of working directly with midwives influenced her distrust. Similar to Ina's observations, in Daisy's experience, the need to surveil the practices of midwives appeared to be influenced by feelings of distrust for midwives, which may be influenced by historically

gendered understandings of nursing roles in perinatal care and a perception that midwives, another female dominated profession, threatened those roles.

Eve, a nurse, was one of several participants who talked about how the visibility of the midwives' practices, during collaboration at a hospital, exposed her to new supportive skills for clients in labour.

And they are wonderful coaches. So, I coached women in labour for a long time, but watching them coach ... Watching the midwives coach, yeah, is great because that's what they have. There isn't anything else to reach for, right? So, when the woman's saying I don't think I can do this, I want an epidural. As a nurse, you say okay, and go call for an epidural. But if what she's expressed to you ahead of time is she would prefer not to have the epidural, I'm not refusing her an epidural but now I do work a little harder with - well, that's available to you but how about we try one of the other things you talked about? How about we try going in the tub? How about we try changing your position? What if we go in the birthing ball? Have you thought about this? We can put some heat on your back, we can massage, we can do some other things, help working on them with focusing. And because they're really excellent coaches, and so even watching ... having watched labour nurses do it for years in another place, coming here and watching midwives do it I saw things I hadn't seen before. So that was great. (Eve, Nurse)

Eve valued the new things she learned from the midwives about supportive care when she watched how they practiced. In a midwifery discourse, midwives are experts in supportive labour care and they are committed to low interventions for low-risk clients, based on clients' choices. In a nursing discourse, nurses care for clients with a variety of risk levels throughout labour and birth, with use of a variety of interventions and supportive care. Although Eve was socialized

with a nursing discourse, which supported the use of interventions, she gravitated towards a midwifery discourse after she learned new supportive care strategies from watching midwives. As a result, Eve's supportive care practices changed and she worked harder not to immediately call for an epidural if the client had previously indicated that she did not want one. The midwives were positioned as experts in supportive labour care, and Eve trusted their expertise once their practices were visible to her. Eve trusted the midwives and their professional abilities and she used her agency to incorporate what she learned from them into her own practices.

### **5.3.2 Resisting and accepting institutional expectations**

The majority of participants discussed their responses to institutional expectations associated with health care and hospitals, that were placed on midwives and nurses working in Nova Scotia. For some of these participants, there was an acceptance of institutional expectations, other participants challenged institutional expectations. Participants talked about how institutional expectations influenced the ways that midwives and nurses collaborated. Collaboration between midwives and nurses was influenced by; the obligations that midwives and nurses had to the institutions that employed them and the institutional spaces within which they worked together.

Jean, a nurse participant, talked about how midwifery births in a hospital had the potential to change the practices of nurses

I think having midwifery births in the hospital as well would really change the way the nurses ... Well, because they know they have to do their 'nurse' kind of things to fulfill their obligations for the institution. But they can learn so much of how they can do things differently, and that it's not looking at the clock and getting things done, it's more looking at the family and are they bonding, did that baby get to breast? And there's no rush to

give vitamin K or eye drops, and that stuff can wait. And I think they're doing a much better job at that. Yeah, and here they have embraced the skin-to-skin big time. And I think it was actually the nurses who took that on in the labour room, in the labour and delivery. They saw it through research that this was a good thing, and let's do it. So I think they moved that forward, which was great. So I mean, it goes with a midwifery model of having the baby with the mom right away. (Jean, Nurse)

Jean positioned a midwifery discourse of perinatal care as an alternative to the medical discourse of perinatal care. In a midwifery discourse, woman-centered care and person-centered care is central to how care is delivered. This means that the client and the client's family are at the centre of care and decide how to birth and when to accept clinical assessments and interventions. Jean believed that midwifery was 'different' and 'more looking at the family.' In medical discourses of perinatal care, institutional guidelines and protocols of hospitals often determine how clients experience labour and birth and when or how they receive clinical assessments and interventions. Jean believed that nurses had to fulfill obligations to the hospital institution in their roles as nurses, when their practices were guided by a medical discourse. Jean believed that nurses could learn about different practices and different ways of doing things from working with midwives in hospital births. She aligned herself with the midwifery discourse and could see where the practices of nurses were changing. For example, the nurses 'embraced the skin-to-skin' in the birthing room. Jean believed that skin to skin practices aligned with midwifery approaches to care, and she valued this change in practice, believing that it was person centered and oriented with a midwifery discourse of perinatal care.

Eve, another nurse participant, believed that midwives could help nurses support clients and families who were either fearful or hostile of the health care system. Eve believed that some

midwifery clients did not accept medical assistance easily, and that, as a nurse, she was viewed by these clients as a representative of the health care system.

And there's differences in the clients too, there's a certain percentage of midwifery clients who have a certain fear or hostility towards the healthcare system. And so we're the big bad, and if they're coming from that perspective, if the midwife lets me know that that's really helpful to me, right? Because then I can be more cautious about what I say or allow any advice to come from her. I tend to keep more in the background, I'll introduce myself and will say - let me know what you need. And try not to ... because sometimes you can ... And some of us are more boisterous and would jump in, coaching, and helping on, and cheerleading. And some people really don't want that, and especially since they don't know you, they see you as a representative of a system that they're afraid of, right?

(Eve, Nurse)

Eve valued when the midwife could let her know if the midwifery clients were afraid of or felt hostile toward the health care system, and the medical model of care. Eve was aware of being positioned as 'a representative of a system that they're afraid of', and as a result, she used her agency as a nurse to change her nursing practices by taking a step back when she worked with these clients. Based on her experiences with some midwifery clients, Eve was aware of a marginalized social discourse where the health care system and hospital institutions within the medical model of care, were believed to be unsafe, untrustworthy, and fear-inducing places of subordination. This was different from the hegemonic medical discourse which upholds the safety, trustworthiness, and authority of hospital births, medical professionals, and the health care system as a whole. Eve was respectful of midwifery clients who were aligned with a fearful or hostile discourse of the health system, and she tried not to reinforce the negative expectations

that clients had of the hospital institution, her, or the health care system. Eve challenged the fearful or hostile discourse of the health system, through her practices of minimizing her presence and deferring to the midwife to provide advice to the client.

Like many other participants, Elisabeth, a midwife participant, also responded to the institutional expectations of her practices in the hospital. She believed that her presence as a midwife at hospital births, created a more relaxed birthing environment. Elisabeth valued her practices, which did not comply with the same expectations of standardized practices for nurses.

I think it definitely brings a very much more relaxed than different environment if a midwife is coming, because we don't have this, oh, strict two hours I need to do this, two hours I need to do this. And even postpartum checks, like, oh, it's half an hour I need to do a newborn check. We don't function like this. And I think what I see and that's I think also a little bit from my background, I mean, it's okay really decades ago where things were different anyway, but also I feel in a big institution like this everything is so standardized, where we are not necessarily working, we are part of this, but how we are working is much smaller. (Elisabeth, Midwife)

Elisabeth believed that her practices were different from the practices of nurses who had to adhere to timelines for clinical assessments. She positioned herself as a primary care provider with the authority to determine when and how she would conduct her practices. Within the current hegemonic medical system, midwives have more autonomy than nurses because midwives are positioned as primary care providers. Two discourses were evident in Elisabeth's experience. The first was a medical discourse where birthing care takes place in a hospital and requires standardized and ongoing clinical assessment and evaluation of patients. The second discourse was a midwifery discourse which approaches clinical assessments in a non-

standardized, individualized way. In hospitals, a medical discourse dominates the practices of nurses, who adhere to standardized timelines and processes for clinical assessments. Elisabeth challenged the medical discourse by not adhering to strict timelines, determined by the hospital institution, for clinical assessments. She aligned herself with a midwifery discourse of individualized care which influenced how and when she practiced. Elisabeth believed that when she was present at a hospital birth, her presence made the environment more 'relaxed' because she did not adhere to the institutionalized standardization of clinical care.

The institutional space also influenced how midwives and nurses collaborated. Both nurse and midwife participants talked about what it was like to work with one another in a hospital setting and how power relations were negotiated within that institutional space between individual nurses and midwives. Ina, a nurse participant, believed that in a hospital setting, nurses were positioned as experts in meeting institutional expectation and in using institutional resources.

Yeah, I mean I think too sometimes you push back a little bit as a nurse and be like - well, actually like I probably know how to work that better than you do. So give it to me. I'm like ... sometimes I'll ask the midwife like do you want a practice of skill, like starting an IV or like putting in a catheter, like because I don't know how often they get to do that stuff, right? And maybe they want to stay up current on their skills, and very often that they don't, they're like, yeah, I'm fine, just you go ahead and do it. But I think ... And often there's like ... there can be a real dialogue between the nurse and the midwife in terms of like ... Like the midwives are trying to figure out, okay, like this is what I think should be the next step in this client's care. Well, what's your experience? Like how

would this look right now? Which is why I think the nurse has so much more power in the hospital than the midwife often does. (Ina, Nurse)

In the institutional hospital setting, Ina believed that there were times when she worked with midwives where she needed to 'push back a little bit as a nurse', asserting her nursing knowledge with the midwife. She believed that she had more expertise in doing particular skills or in using particular pieces of equipment. In a nursing discourse, nurses are always present in a hospital institution and, nurses have certain clinical skills and tasks they are responsible for within that institution. Within a nursing discourse, nurses are positioned as institutional experts in the hospital who are familiar with institutional expectations of, their practices, equipment used in the institution, and orderly conduct. In a midwifery discourse, midwives do not have a continuous presence in the hospital, they are flexible to working in different birthing spaces, and the equipment they are used to working with may differ from what is used in the hospital. Although midwives can use the equipment in a hospital and have the capability to do some of the nursing skills and tasks, they do not have the same level of familiarity as the nurses do with the equipment, procedures, and expectations of a hospital institution. Ina believed that nurses had more power in the hospital than midwives did, which may be a reflection of their historical acceptance of a gendered division of their labour in health care generally, and in hospitals specifically. However, her practices illustrated fluid power relations between herself and the midwives. There were times when she pushed back because she believed she was better at a skill or task than the midwife, and at other times when she offered the midwives opportunities to practice what she viewed as nursing skills or tasks. Ina was able to assert herself as a nurse at certain times, and at other times, she was also comfortable sharing tasks or skills with the midwives.

Many participants talked about how space influenced the way that midwives and nurses worked together. Chelsea, a midwife participant, believed that the birthing space in the hospital belonged to the nurses. She admired how the nurses protected clients within the space and how they led initiatives to improve clinical practices. However, she found it difficult to assert herself as the primary care provider, in the hospital, when she had to take charge of certain clinical situations.

I do feel the nurses, they are so um. Like they are so full of pride and they really take ownership of that birthing space, like it is their own house and they need to keep their house neat and tidy and moving along, you know? And I really admire that sense of, like they're protecting the client and there are, some nurses that have spearheaded initiatives. Like the golden hour. Like that is so admirable, that you were that passionate about that topic, that you've now changed the policy on the birthing unit around the golden hour. That's really admirable, you know. And so I value that they bring that to the space. But sometimes it is more appropriate as a primary care provider to be guiding the path of a certain situation, you know? And so to have to have that conversation with somebody I think I've alluded to this earlier, like it's very difficult, it's not an easy conversation to have you know. (Chelsea, Midwife)

Chelsea believed that nurses owned the birthing space in a hospital. She valued nursing leadership for practice changes and how nurses looked out for clients really admired their protection of clients and their initiative within the hospital. In a nursing discourse, nurses have a continuous presence in the hospital, and they are responsible for the orderly conduct of care in that institution. Nurses are expected to demonstrate leadership and their ongoing commitment to improving client care using evidence. Nurses have also maintained an alliance with medicine,

based on their historical acceptance of a gendered division of their work, and as a result have enjoyed full integration into the institutional structure of the health care system. In a midwifery discourse, midwives are primary care providers who are responsible for clients and who provide care in a variety of settings, including the home and the hospital. Chelsea aligned herself with a midwifery discourse but found the nursing discourse challenging when she had to assert herself as a primary care provider in a hospital institution. Although Chelsea valued the leadership and ownership of nurses in the hospital, she found it challenging to assert herself as the primary care provider in clinical situations in the hospital within the context of the hegemonic nursing discourse. She was conflicted by her alignment with a midwifery discourse where she is a primary care provider, and her admiration of the leadership and ownership of nurses that she was exposed to when she worked within a nursing discourse in the hospital.

Daisy, a nurse participant, who also worked with midwives at home births as a RN Second Attendant and at hospital births, believed that her collaboration with midwives changed for her at hospital births,

There's not much difference. I mean, if it's a low intervention birth at the hospital we can ... there's a little bit more ... there's like the computer element of charting versus just having the paper chart over to the side. I usually take that role. They do some computerized charting, they have access to everything but I just feel like, well, I can do that.... In the hospital. I'm more familiar with it. And I find sometimes I can just stand off to the side, sometimes I can be there, like it all depends on the scenario and what the woman needs. But things definitely change in the hospital, it's a little bit more structured, a little bit more ... there's the policies and procedures and practice guidelines that are ... or the hospital's practice guidelines. Midwives have practice guidelines too, I don't want

to sound like they just do whatever they want, but there's a little bit more of a structure and formality to our relationship and the collaboration, but it's not that different. (Daisy, Nurse)

Although working with midwives in a hospital was 'not that different' from working with midwives at a home birth, Daisy believed that changed when she worked with midwives in the hospital. Daisy reflected that there was more structure and formality in the ways that she collaborated with midwives in the hospital setting. Daisy believed that the institutional policies, procedures, and guidelines increased the formality and structure when she worked with midwives in the hospital, compared to when she worked with midwives at home births. Midwifery discourses have focused on choice and centered the client as the decision maker throughout perinatal care. As a result, midwives are often flexible in the ways they provide care in order to accommodate a variety of choices. Institutional discourses in health care have often focused on efficiency of the delivery of services guided by the creation of structures, to support efficiency, such as standardized policies and procedures. Daisy straddled both discourses when she worked with midwives in the hospital, her practices were flexible in response to the client's needs, but she also believed that it was more efficient for her to do the electronic charting because she was more familiar with it than the midwives were. The practice guidelines and policies were a product of the institutional discourse, which influenced a more formal relationship between herself and a midwife in the hospital. Yet she was aware of an alternate discourse of a less formal way of working together based on her experiences as a RN Second Attendant at home births.

### 5.3.3 The ‘medical approach versus the midwifery approach’

Several participants talked about the differences between a medical approach and a midwifery approach. These participants shared positive and negative outcomes that were influenced by the polarity between these discourses, how the different approaches influenced the way the providers practiced, and the positive influence that the midwifery approach has had on the hegemonic medical approach in perinatal care.

Janet, a stakeholder participant, talked about a conversation she had with a midwife and a nurse about a home birth that they both attended. During the conversation, the midwife described the birth as not particularly outstanding in terms of low-risk home births that she often attended. However, Janet believed that for the nurse who attended the same birth, it was an outstanding birth in comparison to the hospital births she was used to,

And then having spoken to the midwives and also hearing from some of the nurses who were second attendants and how their attending births was completely different for them. And one of the midwives was describing to me that as far as she was concerned it was a very normal birth, there wasn't anything particularly special or different. It was a nice delivery. But the nurse who was with her was absolutely blown away by it. And just suddenly saw the difference from the medical model if you like to the midwifery model and how it was managed different, conducted differently and it was just a very different scenario. (Janet, Stakeholder)

Based on the conversation she had with RN Second Attendants and midwives about their experiences working at home births, Janet believed that there were differences between the medical and midwifery models of birthing care. In medical discourses, the hospital is the birth setting, where clients with a variety of levels of acuity are cared for and hierarchies of roles and

decision making are reinforced. A midwifery discourse includes choice of birth place (including home birth), involves clients who are low-risk, and reduces hierarchies by placing the client as the decision-maker. Nurses who have only worked in hospitals within a medical discourse may be aware of alternative ways of birthing, but may have difficulty imagining what those experiences are like because of the hegemonic medical discourse. Janet believed that the nurse's reaction to the home birth, highlighted the nurse's lack of awareness about the reality of midwifery as an alternative to medicalized birth. Janet valued the impact that the exposure to a home birth, within a midwifery discourse, had on a nurse whose birth experiences had been primarily framed by a medical discourse. What was a normalized birth experience for the midwife was an extraordinary birth experience for the nurse.

Florence, a midwife participant, believed there were two approaches to birth. She reacted to the tension between the two approaches to perinatal care, by sharing midwifery knowledge about a specific clinical assessment skill with nurses at the hospital.

So I had this birth just the other night and I had this ... there was a fourth-year student nurse, and it was a beautiful birth, it was just going to be great, and the woman was on her hands and knees and she was ... I could tell she was fully but she wasn't pushy just yet, but she was starting to sound it. And do you know the like the red line up the bum? ... So you'll never find it in any textbook, but if you look at a woman's bum when she's fully, in between the crest, there's a red line that presents, and that's like she's fully dilated... No joke... No joke. I learned it 20 years ago. It's there. It has never failed me... So I see it, and I'm like ... and I turn to the nurse and I was like ... there's two nurses I was like ... Come here. So I showed it, and I was like you will never find that in any textbook. And she was like, wow. And even the birthing unit nurses don't all know that yet, like I

try to show them. But even the birthing unit nurse that was ... she's a fairly experienced one, she was like oh, I'm like yeah. So there's just ... those are things that you learn because you don't do a vaginal exam every two hours... You do it when it's appropriate, or every four hours, like I trained every four hours. Like two hours is a standard, no, two hours isn't enough time to give a woman time to ... So it's those different approaches that we talked about, the medical approach versus the midwifery approach. So sometimes you see different things. (Florence, Midwife)

Florence believed that there are different approaches to birth influence providers to see different things. In a medical discourse, a vaginal exam is a common clinical assessment used to understand a birthing person's labour progress, based on the status of the cervical readiness for birth. In a midwifery discourse, midwives may use alternative assessments to understand a birthing person's labour progress. Often a midwifery discourse values a reduction in the number of vaginal exams that clients experience and therefore providers working within this discourse will use a variety of observational techniques which can indicate labour stages. Florence practiced within a midwifery discourse and she believed that the need to do a vaginal exam every two hours with a person in labour was a product of a medical discourse. She challenged this medical practice. Florence valued her midwifery education and training to inform her clinical assessment practices and she challenged the practice of conducting a vaginal exam every two hours. Instead, she used her agency as a primary care provider to teach a nursing student and a nurse about a clinical observation, that she learned as a midwife, which indicated when a woman was fully dilated and ready to push the baby out. Florence believed this clinical observation was something that would not be found in a medical textbook. Although this practice had not been validated by a medical discourse, in a medical textbook, it had been a part of her clinical

assessments of labouring women for twenty years. Florence positioned herself as a midwife with twenty years of midwifery expertise who shared her midwifery knowledge with nurses.

Eve, a nurse participant, talked about her experience at a hospital birth with a midwife and midwifery client and how a comment that the midwife made to the client after the birth upset her. She believed that the comment reinforced a dichotomized view of midwifery and home birth versus medicine and hospital birth.

We'd had a person who had hoped for a home birth. And she was followed by the client ... followed by the midwives through her pregnancy, but unfortunately when it came time that she was in labour there was no second attendant available, so she came to hospital. And I became the second attendant. And that was one of the births that I attended by myself with the midwife, because we were trying to keep it as much like a home birth as possible, and luckily it was progressing very naturally and normally. And I thought that it went really well. From my perspective like it seemed like this is great, this is as much as possible I can't be at her home, but we achieved I think what she was looking for. And unfortunately at the time the midwife involved said to the patient afterwards, and I think she meant well but it really, it hurt. She said, 'well, if you had to have a hospital birth that's as good as you could hope for'. And just the way it came out, and I think I know what she was going for was that wasn't, I know you couldn't have your birth at home but how did that go? But I just felt really small. She said in the room and I thought - as a midwife you're not discouraging people from the idea that the hospital is the enemy, if they don't see you seeing the hospital as a good place they're definitely not going to, right? (Eve, Nurse)

Eve believed that although the birth took place in a hospital, that she and the midwife had achieved what the midwifery client was looking for in a birth experience. She valued being a part of creating a home birth like experience for the client who wanted a home birth but who ended up with a hospital birth. Following the hospital birth the midwife said to the client 'well, if you had to have a hospital birth that's as good as you could hope for.' This comment was upsetting to Eve, because she had worked hard to make the experience as close to a home birth experience as possible in the hospital for that client. Choice of birth place is an important part of a midwifery discourse, where home and birthing centres are believed to be as safe places for low-risk births. In a medical discourse, the hospital is believed to be the safest place for women to birth. Eve valued the wishes of the client who wanted a home birth and tried to make the hospital birth as close to a home birth experience so that the client had a positive experience, and she believed the birth went well. Eve questioned the midwife the midwife's reinforcement of opposition between a midwifery (home birth) discourse versus a medical (hospital birth) discourse. Eve wanted the midwife to share in her efforts to present a united message of the health care team rather than reinforce a polarity between the medical and midwifery approaches to perinatal care.

Melissa, a stakeholder participant, talked about how midwives provide nurses with an alternative way to support birth when they work together. Melissa believed that midwives brought 'a feminist perspective' to the provision of care, which centered the client as the decision maker concerning birth place and birth experience, and led to feelings of empowerment for that client. She positioned the midwifery approach as an approach that was different from the way that many providers usually provide birthing care.

Well, I mean, I can't say I'm an expert because I'm not a midwife so I wouldn't say I know what midwifery philosophy is all about. But I mean, kind of those basic tenants

around choice and the right to choose for ... the right to choose their care provider but also choose where they want to give birth and choose how they want to have their birthing experience unfold, so a lot around that right to choose. But also philosophies around low intervention, so first do no harm, minimal intervention kind of philosophy. And sometimes women may think they want these other ... all these other interventions, but it's more because they don't know about all these other opportunities. And same with nursing, so the nurses might think, "Well, gee, just give them the epidural. They're just sitting there, they're in no pain." But if they knew about all those other low intervention that really empowers women, because they want to create a birth experience that really truly empowers women, that they're now going to use their birth experience, that fosters so much more and will enrich their life of parenting and as women. So it's kind of that feminist perspective that I think they bring. And not to say that other professions don't bring that, but I think that's so much more foundational to how they approach anything that they're doing. (Melissa, Stakeholder)

Melissa valued the contributions that midwives made to the delivery of perinatal health care services and she believed that midwives offered an alternative to the way the birth was usually attended to by nurses. The midwifery discourse has reinforced midwifery as a profession that is feminist, woman-centered, holistic, values choice, lowers interventions, and values clients as experts in their own care and needs. The medical discourse of perinatal care has been understood as patriarchal, provider-centered, with high rates of interventions, restricted choice, and providers as experts in clinical care and client needs. Melissa believed that the inclusion of the midwifery discourse, through the inclusion of midwives, was a positive alternative to the medical discourse. She believed that midwifery care was empowering for women and enriched women's

lives and their parenting. Melissa, believed that midwifery had the potential to change the practices of nurses who may only be aware of interventive approaches to birthing care, and the choices of women who may make decisions about their care based on the hegemonic medical discourse. These changes in practices and decision-making, have the potential to influence more empowering birth experiences for women. For Melissa, the feminism was the foundation of midwifery as an alternate and empowering approach to birth.

### **Summary**

All of the participants experienced or were aware of experiences of systemic tensions in terms of how nurses and midwives positioned themselves in relation to midwifery and medical discourses, and the expectations that corresponded to the different discourses, when they collaborated. Participants negotiated the (in)visibility of their collaborative practices in different ways, while other participants resisted and accepted institutional expectations of their clinical practices. The historic dichotomy between midwifery and medicine continued to influence the ways that midwives and nurses collaborate, with nurses often straddling the two discourses depending on whether they collaborated with a midwife in a hospital or home setting. Midwives often challenged medical discourses through the alignment of their clinical practices with a midwifery discourse and by using their agency to share midwifery knowledge with nurses.

### **5.4 Moving forward: A Modern Model for Nurses and Midwives Working Together**

In this theme I present how collaboration between midwives and nurses has the potential to provide the foundation for a modern model of perinatal care. The majority of participants in this study talked about how collaboration between midwives and nurses was a model that could be used to move forward perinatal care, in terms of improving experiences and outcomes for clients and providers. The sub-themes that contribute to this main theme are; 1) 'The culture has

changed' 2) Advocacy, 'allies and advocates.' Each of the sub-themes will be presented in more detail below.

#### **5.4.1 'The (birthing) culture has changed'**

Most of the participants in the study talked about how collaboration between midwives and nurses was a catalyst of change for the culture of the delivery of perinatal care and for the ways that perinatal care has been provided in the health care system. In terms of how collaboration between nurses and midwives influences the culture of perinatal care, participants talked about; how understanding the midwifery philosophy influences collaboration, how nurses have learned to adapt clinical practices to new (home) environments, how the birthing cultures in hospitals have changed, sharing midwifery principles with other providers, and their visions of midwives and nurses as a model of care for the future. Although the participants talked about different ways that the inclusion of midwives has changed clinical practices and the birthing culture, they all believed that the inclusion of midwives, and the midwifery approach made positive contributions to perinatal care.

For several midwife participants, sharing a midwifery philosophy of perinatal care with nurses influenced the ways that they collaborated. Chelsea, a midwife participant, believed that working with nurses in the hospital who also attended home births as RN Second Attendants made their collaboration 'a real ease of practice.' She valued that RN Second Attendants understood the midwifery philosophy of care, and this meant that she did not have to take the time explain some of her practices to them at hospital births.

I do find it that when I'm working on the [birthing] unit with one of the nurses who is also a second attendant there's just a real ease of practice. It just flows differently. It's just, they get, it's just like it's not just about the clinical skills or the supportive care it's the

whole philosophy of what midwifery is and how we serve our clients. They're already there, I don't have to explain to them why I'm doing informed choice about an IV, you know? I don't have to explain, why I am giving my client another moment to come to terms with a particular decision in terms of taking up time when we could have already gotten to what we're getting to, you know? They get our philosophy. They share, I would assume, that they share, a philosophy with us and that's why they're working with us in that intimate way. (Chelsea, Midwife)

Chelsea, believed that working with RN Second Attendants, who also attended home births with midwives, was different than working with nurses who were not RN Second Attendants. Chelsea believed that the RN Second Attendants understood and shared the midwifery philosophy.

Chelsea's practices changed when she worked with RN Second Attendants because she did not have to explain why she approached some practices, such as informed consent, in the ways that she did. Chelsea could focus on ensuring that the clients made informed decisions about all aspects of their care or had time to embrace a decision. She did not have to explain or justify to the RN Second Attendants why she took the time to ensure that client decisions were informed and understood. Informed choice and clients as the decision-makers for all aspects of care is central to a midwifery discourse. Midwives educate clients about their options and facilitate the decisions that clients make, ensuring that clients are supported to make decisions. Informed choice is also an important aspect of a medical discourse, however patriarchal influences, that place a physician in a role of authority for decision-making, continue to dominate the discourse, and decisions are often still made by health care providers for clients. For a nurse who does not know or understand a midwifery discourse of informed choice, having a midwife take time to ensure that the insertion of an IV during labour was an informed choice may seem strange. This

is a task that nurses do all the time, but if a nurse accepts a medical discourse about informed choice, she may not approach a conversation about informed choice for an IV insertion the same way that a midwife does. Chelsea was used to working with nurses who worked within a medical discourse of informed choice, and she explained her reasons for approaching informed choice with clients to those nurses. Chelsea's practices changed when she worked with RN Second Attendants because she knew that they had been exposed to the midwifery philosophy of care and midwifery practices. She did not explain her reasons for taking the time to ensure clients were completely informed about clinical interventions because the RN Second Attendants understood the midwifery philosophy of care.

Annabelle, another midwife participant, talked about her experience watching a nurse's practices change. Providing birthing care in a home was something Annabelle was comfortable with but for a RN Second Attendant providing birthing care in a home setting was new.

I remember once having a homebirth down there with our second attendant and she was like just a little thing like climbing onto the bed to do a blood pressure and she was like this is so weird I've never done this before. You know she just got right into it and she's like, it just kind of came over me as a very natural thing to just go up there and climb onto bed with her and do it. And I was thinking if I was in her home when I feel comfortable doing that. Where you know for us, we will walk into someone's home, no problem. If they're in labour, I will walk in there and I will search everywhere until I find her. But for her, it was like wow okay so this must be what it's like at home I'm just like okay, I'm just going to crawl up onto your bed and do a blood pressure and check your fundus. So that was kind of a cute little like oh yeah, nurses weren't raised in that culture. Where for us from like day one, we were taught about like home birth and doing

home births and being at home births. So it was a very different kind of philosophy and ideas but, yeah. (Annabelle, Midwife)

Annabelle was surprised at the nurse's reaction to climbing onto the client's bed to do a blood pressure as 'so weird I've never done this before.' For Annabelle, a home setting was an environment that she was comfortable working in because it was a setting she had been introduced to early in her education, and as a result, she was comfortable adapting her practices to meet the needs of the client within that setting. The nurse was not used to working in a home environment, having worked in the hospital, where climbing onto a client's bed to do a blood pressure was not part of her practice. The nurse was used to working in an institutional hospital setting that maintained a professional distance from a client. In a nursing discourse, a nurse would not climb onto a patient's bed to do a blood pressure. A nurse may sit at the side of the patient's bed or in a chair, but, unless there is an emergency situation, it would be unlikely that a nurse would need to climb onto a bed to do most clinical skills because the hospital environment has been designed in part, for the efficient delivery of clinical care. In a midwifery discourse, flexibility is important in order to meet the needs of clients, wherever they choose to birth. Homes are not designed for the efficient delivery of clinical perinatal care, and when midwives provide birthing care in the home, they must adapt their practices to keep the client comfortable and to meet the client's needs. Annabelle valued how the midwifery discourse influenced how she adapted her practices to meet the client's needs and she observed how the nurse negotiated her practices to adapt to the home setting. The nurse's practices challenged the nursing discourse and reflected the midwifery discourse of flexibility to accommodate the client's needs in the home environment. Annabelle understood how this was new for the nurse.

Many participants talked about how collaboration between midwives and nurses was changing birthing culture in the hospital setting and how it had the potential to change birthing practices and culture. Florence, a midwife participant, talked about how she has seen a change in the culture in the hospital where she worked, over her years of practice. She believed that nurses have become more comfortable with low-risk, non-medicated births, and that their exposure to low-risk births with few interventions, as well as working with midwives, has contributed to this change in culture.

I feel like one of the unfortunate parts of perinatal nursing is that if they don't get exposed to low-risk stuff then high-risk is the only thing they're really comfortable with. Interestingly when we started, all the young nurses were the ones that really wanted to work with us, and then within a few months they didn't like working with us, and it was the old gals that liked working with us. Because the old gals remember what it's like to look after women without epidurals and the young gals were trained in a world of epidurals, and they were ... Yeah, they were very comfortable with pumps and epidurals and all that, but being with a woman in labour who was in pain and being comfortable with that they were not happy with it. And now all those like the newer nurses they're awesome, like they're totally into normal birth now. The culture has changed

dramatically. (Florence, Midwife)

Florence believed that it was important for nurses to be exposed to low risk births, where clients do not always have epidurals for pain management because this exposure enhanced nurses' comfort in providing care to clients with these profiles. She observed that over time, and as the nurses worked more with the midwives, who provided low-interventive care to low risk clients, the nurses became more comfortable supporting clients in labour who did not have epidurals. In

a midwifery discourse, midwives provide care to low-risk women, are experts in supportive care for unmedicated labours and births, have lower rates of interventions for clients, and support “normal” (non-interventive) birth. In a medical discourse, which is hegemonic in many hospitals, medicated births are common and normalized, (requiring different supportive care measures than unmedicated births), there are higher rates of interventions which are normalized, and more variety in the risk level of women. Nurses are often aligned with a hegemonic medical discourse that normalizes medicated births and interventions, when they work in hospitals. Florence believed that the introduction of midwives, and a midwifery discourse of birth, has changed the birthing culture where the nurses are interested in and supportive of normal birth. Florence believed, ‘The culture has changed dramatically’, and this change was a result of midwives working with nurses during low-risk and non-epiduralized births. At Florence’s hospital institution, midwives and nurses have been integral for the change in birthing culture.

In terms of the potential that collaboration between nurses and midwives has to change birthing culture and practices, Janet, a stakeholder participant, believed that nurses were uniquely positioned to share what they learned from midwives with physicians. She believed that sharing midwifery knowledge with other providers could strengthen perinatal care as a whole. For Janet, nurses had an integral role in disseminating midwifery knowledge.

So I think that's where it should be strengthened and more and more nurses if they have the ability and capacity to become second attendants and see what happens with a midwife delivery. Can they take those principles back when they are involved with a physician and say, "Well, how about if we do this and how about if we do that? And I saw a mom sitting or hanging or doing whatever and it helped with her pain relief. And maybe that is my answer to how it can be strengthened. But I think just that support and

dynamic that there is with the midwifery and mom the nurses, we could learn a lot from that and use that when they are supporting doctors and moms in a delivery. (Janet, Stakeholder)

Janet believed there was a dichotomy in the ways that midwives and physicians practiced. Although Janet did not articulate exactly what the differences were between the practices of midwives and physicians, she valued that midwives may have alternative strategies for pain management in labour. A midwifery discourse has often been centered around supportive care for women who are unmedicated during labour. Many clients who choose unmedicated births choose midwives as their care providers because of the expertise midwives have for supporting unmedicated births. This contrasts a medical discourse where physicians and nurses often care for women who choose pain relief medication, such as epidurals. The distribution of pain relief medication to women has become a common practice within a medical discourse and as this pain relief strategy has increased in use, the skills for supporting an unmedicated birth have decreased amongst nurses and physicians. Janet saw potential for nurses to be agents of change who could incorporate midwifery principles, such as alternative strategies for pain relief in labour, into their practices with physicians. Nurses worked with both midwives and physicians and were therefore exposed to both midwifery and medical discourses. She questioned whether nurses could challenge the medical discourse by sharing what they had learned from the midwives with other providers, such as physicians. Janet positioned nurses as potential conduits for sharing aspects of midwifery care with physicians and changing practices. In Janet's experience, nurses were strategically placed to influence practice changes and champion midwifery within a model influenced by a hegemonic medical discourse.

Susan, another stakeholder participant, valued the role of RN Second Attendants and she believed that the way that perinatal care was delivered could be changed. She believed that there should be more nurses should be working as RN Second Attendants for home births in Nova Scotia, even though there were challenges to increasing the numbers.

I do value our role of having the nurse and the midwife together in birthing unit, I do very much value the role of having maternity nurses be the RN Second Attendant because I think that just changes the culture of the program and that's how we'll change obstetrics and maternity care delivery. But I understand that other areas might be very limited in the number of maternity nurses that they have, maybe they all have young families, they just can't take on an RN Second Attendant role at this time. So I don't want to be to say - this is how it should be. Because there's all kinds of factors that come in place, but in a perfect world ..... I'd like to see that ... even have to be a nurse from the maternity program who was an RN Second Attendant, and that every site would have RN Second Attendants working with the midwives. Because I think that is the catalyst for change in the programs. (Susan, Stakeholder)

Susan believed that the delivery of perinatal care needed to change, and like Janet, she saw the potential that nurses had for contributing to these changes. Although she did not describe the changes that needed to occur, beyond the need for more RN Second Attendants, she believed that collaboration between nurses and midwives was an important aspect of the delivery of perinatal services. One of the challenges that she identified for increasing the number of RN Second Attendants were the gendered tensions between women's work and family responsibilities. This is not a new challenge for nursing or for midwifery which are both professions dominated by women, and who have been faced with competing priorities between professional work and work

at home. A discourse of motherhood values the expectation that mothers prioritize their young children and families ahead of, or in relation to, their career goals. Traditionally, a discourse about planning for the human resources needed to deliver health services has prioritized the institutional needs of hospitals. Historically, this has meant that a hospital, requiring twenty-four hour nursing staff to deliver health services around the clock, filled that staffing need with nurses working shifts within the hospital institution. If a nurse is a RN Second Attendant, then she must commit to specific on-call times, in order to be available for a birth, which could occur at any time of day or night. A perinatal nurse who does shift work and chooses to be an RN Second Attendant, would use time not spent in the hospital being on-call and attending births. RN Second Attendant roles were not integrated into institutional staffing needs at the time of data collection, so the work of an RN Second Attendant was above and beyond the staffing expectations of nurse employees of the hospital institution. This means that nurses often needed to choose between time with family and time being on-call or attending home births as RN Second Attendants. Although Susan did not offer a solution to this challenge, she believes it must be addressed in order to increase the number of RN Second Attendants.

Some participants talked about how collaboration between midwives and nurses could provide a foundation for the creation of new models of perinatal care. Daisy, a nurse participant, believed that collaboration between midwives and nurses was a 'modern model' of care. She believed that midwives and nurses were capable of working together in contexts beyond the setting of a birth, time of birth, or the immediate postpartum.

Well, I think if it's ... I think that's a modern midwifery model, if we can have nurses collaborating with midwives. And working like why can't a nurse go work at the midwifery clinic with them and work with them in their office and see patients? Like we

should be doing things like that. I think if we can just change the way that the whole model of care, like that would be ideal. But yeah, I think like we should be working with them in having like a modern model for nurses and midwives working together. (Daisy, Nurse)

Daisy valued opportunities for nurses and midwives to collaborate, including opportunities to work together in other settings such as the midwifery clinic. Daisy believed that the whole model of care needed to change to one where it would be possible for midwives and nurses to work in a variety settings and in a variety of ways. For Daisy, there was a conflict between the model she currently worked in and her vision of what a model of perinatal care should be. The discourse of the medical model of health care has a history of patriarchy and hierarchy, where physicians (who were historically male) had the highest rank amongst health care providers. Health care structures such as equipment, like hospital beds, and practices such as having women give birth in the lithotomy position were created to make the delivery of health care services easier for the provider, not the client. The discourse of midwifery care has a history in feminism and non-hierarchical relationships, where women are the center of all aspects of clinical care and decision making. In the midwifery discourse of health care, the delivery of health care services are made easier for the recipient, not the provider. Midwives were integrated into an existing health care system, governed by a hegemonic medical discourse, and shared their feminist and non-hierarchical approaches to care with nurses. Daisy, believed that midwives and nurses were only able to work together in certain ways right now, which was informed by an existing model of care. She valued the contributions of midwives and she saw lots of potential for nurses and midwives to create a new model of care. For Daisy, a midwife and nurse model of care would be transformative, with more flexibility and innovation for the ways that midwives and nurses could

work together and more opportunities to expand collaboration between the two professions. This suggestion of a midwife and nurse model of care could challenge the hierarchical and patriarchal structures within the health care systems, using the historically gendered aspects of their roles as a starting point.

Bridget, another nurse participant also talked about how collaboration between nurses and midwives could be an alternative to current models of perinatal care. Her vision included a separate physical space from the hospital, staffed by midwives and nurses who could provide all aspects of perinatal and postpartum care, including home visits. In this space, nurses and midwives would have appropriate funding for the delivery of their services and they would be paid for their work.

We always say okay what's our pie in the sky? If we could have all the money in the world, and we'd still get paid, and we still have our benefits... And I said our pie in the sky would be, say that building over there, and it would be our maternal child space. And it would have a midwife, it would have the lactation consultant, it would have a perinatal nurse. It would have.. we would draw our own blood, we would do our own ultrasounds, and would see all women prenatally. We would deliver in that facility, we would care for them postpartum if they needed to come in, we would do our home visits. We would love to have a house to do that and we'd be our own little team and we would totally support moms start to finish. That's our pie in the sky. (Bridget, Nurse)

Bridget valued collaboration between nurses and midwives and she believed that midwives and nurses had the skills and abilities to provide prenatal, intrapartum, and postpartum services to women in the community. There is a medical discourse, which has become a social discourse, which supports the belief that birthing care should be provided in a hospital by physicians and

nurses. In this discourse, a physician is the primary health care provider and care is organized around institutional expectations of a hospital and the physician's availability. A midwifery discourse maintains the perspective that birth is not an illness, but rather it is a normal life event, and as long as everything proceeds within the parameters of what has been deemed low-risk, perinatal care should be provided in the community or in the home, and not in the hospital. Bridget's vision of a nurse and midwife-led team, in the community, challenges the hegemonic discourse that birth and birthing care should be led by physicians and occur in the hospital or in medical clinics. Bridget's vision is aligned with a midwifery discourse, and challenges the hegemonic medical discourse by providing an alternate vision of what birthing care could be, suggesting that birth and birthing care should be moved back into the community as a normal life event. Bridget's vision of a new model of care created around collaboration between midwives and nurses, positions nurses and midwives as leaders in the provision of low-risk perinatal care, which further resists a medical discourse where physicians are positioned as the leaders of perinatal care.

#### **5.4.2 'Allies and advocates'**

Many participants talked about the need to advocate for midwives and midwifery. When it came to the relationship between midwives and nurses, participants talked about how nurses advocated for midwives amongst other health care providers and how some nurses educate women and the community members about midwifery as an option for perinatal care. Participants also talked about how nurses were strategically placed, professionally and politically to be visible allies for midwives, to advocate for midwives, and to promote midwifery. Advocacy for midwifery was believed to be needed in order to improve general understandings of midwifery and to increase the visibility and numbers of midwives in Nova Scotia.

Florence, a midwife participant, described how a nurse vocally advocated for her role as the primary care provider in a room of obstetrical personnel who were present in a consultancy capacity for a vaginal breech birth.

We're running into the room, and I ran into the room and she was pushing. And because it was that fast, and there was like two or three nurses, there was I think there was a neonatal team, there was two residents. And I ran into the room with the obstetrician because we ran into each other in the stairwell, right? And we're running up the stairs and I'm like - this is just a consult, right? You know that, right? Because it is a consult, it's not a transfer of care, even though it's something that we don't do very often. And obviously I would ... I need obstetrics in the room. But I walked in the room and there was a resident kneeling down next to the bed with a pair of gloves on, and the nurse came out and said, Florence, do you need an apron? What size gloves are you? Like loud enough to be like sending that message of, Florence, you're here now and we know you're taking over. It was awesome. I was just like, oh, you rock. So yeah, like that's the kind of respect and trust and collaboration that's there. That's really great. (Florence, Midwife)

Florence valued the nurse's advocacy for her as the primary care provider in a situation where the resident had assumed the primary care provider role in a midwifery client birth. She believed that the advocacy of the nurse on her behalf was reflective of the respect, and trust she had with the nurses. In a medical discourse of the hierarchy of perinatal health care providers, obstetricians are positioned as experts in high-risk births who have the expertise to handle birthing situations that may be uncommon. Obstetricians as primary health care providers are often associated with a high use of interventions. In a midwifery discourse, midwives are experts in low-risk births, have low rates of interventions, and try to reduce hierarchies of care. Florence

used her agency to assert her role as a primary health care provider to the obstetrician, and outlined her expectations that it was a consult, not a transfer of care. When Florence entered the birthing space, the nurse used her agency to assert Florence's role as primary care provider, even with the resident being physically ready to assume the primary care provider role. In this situation, both Florence and the nurse challenged the medical discourse of a gendered and hierarchical ordering of health care professionals. Instead of submitting to the institutional hierarchy of the obstetrics team in charge, they both advocated for Florence's role as the one 'taking over' the role of primary care provider when she entered the birthing space.

Several participants talked about the need to advocate and educate others about midwifery and homebirth as safe and integrated options in perinatal health care. Daisy, a nurse participant, talked about how she often found herself advocating for home birth, her work with midwives, and midwifery as a possible option for perinatal care.

A lot of people say, oh, my gosh, you'd go to a home birth or you would deliver, like these moms would deliver at home, and I find I'm often advocating for the program and letting people know, because there's a real deficit of knowledge out there. They don't know how safe it is and how we've got the birthing unit on standby, we've got an ambulance on standby, we or EHS at least, and we have all the resuscitation gear. People think that you're going on to deliver and like being cut off from all the modern medical technology, but that's not true. So I find when I'd say ... I tell people about it a lot because they just don't know, and when you talk to them they're like, oh, I didn't know that. And it's a segue into, well, are you familiar with the midwifery program or whatever? You're pregnant, have you thought about having a midwife? So it's kind of ... I totally support

nursing and I think as a nurse I can be a good advocate for more collaboration among the two professions. (Daisy, Nurse)

Daisy worked within a hegemonic medical discourse where the hospital was accepted as the place to give birth. In this discourse, home is considered an unsafe location for birth where it is removed from technology and back up for emergencies. In a midwifery discourse, home birth is believed to be a safe option for women who meet low-risk criteria. She aligned herself with a midwifery discourse of homebirth and she challenged this discourse by positioning herself as an advocate for home birth and midwifery. To address a lack of knowledge about homebirth, she educated people about the safety of home birth. As a perinatal nurse, Daisy was in a position to speak to people about their birthing plans and decisions, she used her agency in this role to initiate conversations with people about the safety of home birth and about the midwifery program. Daisy valued nursing, home birth, the midwifery program, and her collaboration with midwives.

Chelsea, a midwife participant also believed that more people needed to be aware of collaboration between nurses and midwives, and to understand that midwives are collaborative and professional members of the perinatal health care team. She believed that nurses were politically positioned with a strong voice in Nova Scotia.

Advocate on our behalf. You know, stand up for us. Use their voice, because nurses have a way more powerful voice in this province than midwives do. Power in numbers, and there's a whole lot more of you. And, so the more we interact with nursing and I'm hoping or assuming that it's in a positive way, that they share that message and spread that message so that other people are aware that we collaborate with the midwives, we do it well. Midwives are extremely professional, well-educated primary care providers that

serve their clients very well. And view that as a good thing rather than something they need to be afraid of. Because I do think that there is that piece of it, right? It's like if they're really good at that, does that take something away from what we bring to the table. And I think that it's not just a potential thought pattern for nurses but for other primary healthcare providers. (Chelsea, Midwife)

Chelsea believed that nurses could help to address misunderstandings about midwives and midwifery care in Nova Scotia. She believed that nurses were positioned systemically and politically to advocate for midwives and educate others about the professionalism, education, and services of midwives. In a nursing discourse, nurses are trusted professionals. Nurses outnumber other professions in health care and they are believed to have political and systemic influence as a result. In a nursing discourse, nurses are expected to be advocates for marginalized people and improved health outcomes. Chelsea appealed to a nursing discourse of nurses as trusted professionals, with political and systemic influence and believed that nurses could use their influence to advocate for midwifery. In the midwifery discourse in Nova Scotia, midwives are marginalized because they are fewer in numbers and generally misunderstood as a profession by the public, health care providers, and the health care system. Chelsea believed that nurses were politically and systemically positioned to help educate the public about midwives. Nurses choosing to advocate for midwifery aligns with a nursing discourse of advocacy for marginalized persons and improved health outcomes.

Emma, a service user participant also believed that nurses could be allies and potential advocates for midwives. However, Emma also questioned nurses' ability to take on the advocacy role for midwives, recognizing that nurses face their own challenges within their profession. She

believed that nurses were positioned to share their experiences working with midwives and ask for more midwives to be a part of the perinatal health care team.

I think they do, I think they can serve as like allies and advocates for midwives. But I'm not sure, because like the health care system there's like so many moving parts, and how do you make a change? Because as it is like nurses we're not in the ideal position either, we have so many barriers and obstacles that we're still trying to overcome in terms of providing care to people and their families. But I think just lobbying and being in a position to support midwives, like being more vocal about wanting to if we want to work with midwives more and see midwives, like if nurses are having great experiences with midwives then asking for more midwives to be present in birth. (Emma, Service user/Mother)

Although Emma believed that nurses should advocate for midwives and talk about their experiences working with midwives, she was also aware that nurses face many challenges within their own profession. In Nova Scotia particularly, and also at a global level, there is a discourse about the need for more midwives and a need to support midwives politically and systemically. In this discourse, midwifery has often been a marginalized profession in terms of funding, staffing, and inclusion which reflects gender inequalities because midwives and their clients, are predominantly women. In a nursing discourse, advocacy is upheld as an important part of nursing practice which should be used to champion and support marginalized groups. Emma recognized the need for more midwives and more support for midwives in Nova Scotia, but she questioned the nurses' ability to advocate for midwives because of their own professional and gendered challenges that required advocacy. Emma was conflicted by both the midwifery discourse of supporting the need for more midwives and the nursing discourse of advocacy, but

she seemed to reconcile both discourses, in her belief that nurses should be talking about the need for more midwives and their experiences with midwives.

Colin, a midwife participant talked about how she would like to see nurses support midwives politically. She believed that families' voices were heard when it comes to midwifery, but that nurses' voices were absent.

I think that we hear the families' voices, but we don't hear from the nurses... like we support midwives because. So nurses have a freaking strong union and they have numbers. And if you put the numbers that have been working with us together and the nurses' union could say, this is why we feel it's a value to our system, that would be huge, so great. That would make me cry probably, that would be awesome. And then if they could be a little more vocal to management about either the challenges that they see or the things that are going great. Because both are helpful, right? The challenge is where we need the help, but the positive feedback, and it's unfortunate that nobody has time. I get that. And they want to be supportive but they also don't want to ... I think they don't want to complain, but we need that honesty and we need management to hear. So we need the public to hear if the nurse's union could go with more, a little more politically there, or even just groups of them. (Colin, Midwife)

Colin valued the political strength of the nurses' union and how nurses could lend their voices to supporting midwives publically and in terms of institutional management at the hospital. There is a social discourse that nurses are a politically powerful group of health care providers because of their large numbers and because they have a union that represents them. In addition to political advocacy for the profession of nursing, the union ensures that nurses and the challenges that nurses face are visible to the public. In a social discourse of midwifery in Nova Scotia, midwives

do not exist in large numbers and they are therefore not visible to the public as members of mainstream perinatal health care teams. Midwives in most Canadian provinces are not unionized, and they do not have the visibility or advocacy support of unions. With only twelve midwifery positions currently in Nova Scotia, the Nova Scotia Association of Midwives does not have the human or financial resources for ongoing advocacy and visibility. As a result, a social discourse of midwifery as a visible group of perinatal health care providers in Nova Scotia is not mainstream. Colin believed in the nursing discourse that positioned nurses as collectively strong politically and systemically and she appealed for assistance from nurses in raising the profile of midwifery. Colin, believed that although midwives were part of the health care system in Nova Scotia, their small numbers and lack of union support made advocacy and increased visibility challenging. Colin believed there was potential in forming a political alliance with nurses who could help advocate for midwives and increase the visibility of midwifery in Nova Scotia.

Similar to other participants, Elisabeth, another midwife participant, talked about how nurses could promote midwifery. She was conflicted about promoting midwifery because midwives could not currently meet the demand for them to be primary care providers to women at the three model sites in Nova Scotia.

I mean, they can promote midwifery. I mean, that's what I think, they can still talk about it, they can promote us. On the other hand we can't meet the demand, it's a little bit obvious I'm thinking. But definitely support us, and as I said like hoping to have an influence on culture, spreading the word, supporting this idea. (Elisabeth, Midwife)

Elisabeth was conflicted by a need to promote midwifery to increase public knowledge of midwifery as an option for perinatal care and the reality that midwives who worked in Nova Scotia have been unable to meet the demand for midwifery services as they were currently

configured. She believed that nurses should support midwives and share their support widely. An evidence based discourse about midwifery and midwifery care indicates that midwifery-led, continuity of care models of perinatal care provide excellent outcomes for low-risk women and their newborns. In this discourse, midwives are the most appropriate care providers for clients who meet low-risk criteria for birth. Although there is research evidence to support this discourse, it has not been fully supported or adopted by decision-makers in the medical model of health care and this may be related to the gendered nature of the work and workforce of midwives globally. There were not enough midwives in Nova Scotia to meet the demand for their services, and to date there has been no political plan or commitment to expand midwifery services equitably throughout the province. Instead, the hegemonic discourse that prevailed was one that situated birth as most safely conducted within hospitals and directed by physicians. Elisabeth situated herself within the midwifery discourse, and valued the contributions of midwives. She believed that nurses could promote and support midwifery, however without appropriate resources and adequate staffing, she does not know how the midwives as they are currently practicing could accommodate more demand for their services.

### **Summary**

In this theme, participants discussed a number of aspects of how this collaborative model can change and improve perinatal care for midwives, nurses, and clients. These aspects included; how working together changed practices and culture, ideas for new models of care with midwives and nurses positioned as leaders, the value of nurses' advocating for midwives, and the need for more political awareness and strategic political alliances between nurses and midwives. Overall, participants valued opportunities for nurses and midwives to collaborate and they

believed that collaboration between midwives and nurses two professions, has the potential to change and create new models of perinatal health care.

### **Summary of Chapter**

In this chapter, I presented the four main themes and eleven corresponding sub-themes of this research study. Overall, collaboration between midwives and nurses in Nova Scotia was often experienced positively. Nurses and midwives were flexible in the crossover of their roles and practices, and they worked hard at sustaining their relationships with one another. Midwives and nurses were faced with systemic tensions, particularly when midwifery and medical discourses intersected through their practices. They reconciled systemic tensions in different ways when they collaborated, either through challenge or acceptance. Finally, participants talked about how the experiences of midwives and nurses collaborating has the potential to provide the foundation to create new and innovative models of perinatal care.

## **Chapter 6: Discussion and Implications**

In the findings chapter I presented the experiences of participants as they related to the research question using feminist poststructuralist discourse analysis to explore and understand the beliefs, values, practices, and discourses that influence the complex interactions between midwives and nurses when they collaborated in Nova Scotia. In this chapter, I discuss four recurring discourses from the findings and situate these within existing literature. The four discourses are; the sustainability of midwifery; nurses and midwives practicing within hegemonic medical discourses, person-centred care, and a new model of care.

I begin this chapter with a discussion of the sustainability of midwifery in Nova Scotia, how this reflects wider global challenges in the delivery of sustainable perinatal health care, and how these challenges provide opportunities for innovations in the delivery of perinatal health care. Secondly, I address the historically informed dichotomy between the midwifery and medical approaches, and suggest that nurses have the potential to challenge and transform the positioning of health care providers within and between these polarizing discourses. Next, I discuss the nurse developed theory of person-centred care and how it offers a framework for midwives and nurses to transform the historical dichotomy between midwifery and medicine discourses, into an inclusive, respectful, and relational approach to collaborative perinatal health care. This will be followed by a vision of a new collaborative model of perinatal care, led by midwives and nurses that has the potential to improve the challenges associated with limited capacity and sustainability of midwifery services in Nova Scotia and in Canada.

### **6.1 Sustainability of Midwifery**

In this study, the sustainability of midwifery was supported by the relationships between midwives and nurses, this was reflected in the theme of: Sustaining relationships: ‘The more we

can just build relationships with one another.’ Trust was important for the midwives and nurses who collaborated and participants described their interest in having more opportunities to continue to build and sustain the relationships that they developed with one another. The sub-theme “Midwives depending on nurses, ‘we could not do our job without them’ specifically reflected how midwives depended on nurses, and collaboration with nurses, in order to maintain and sustain midwifery services, especially home births services, where introducing nurses as RN Second Attendants had ‘salvaged home births.’ The discourse of the need for sustainable midwifery services has is not limited to Nova Scotia, but extends to other jurisdictions in Canada and world.

In Nova Scotia, the challenge of sustaining midwifery was highlighted recently, during participant recruitment for this study in the winter of 2018. Midwifery services at one of the three model midwifery sites in the province were suspended due to a change in staffing (Rankin, 2018) which left one midwife covering all aspects of midwifery care including the maintenance of an on-call schedule. This was unsustainable, and the health authority suspended midwifery services until the staffing was brought back to full complement in August of 2018 (Nova Scotia Health Authority, 2018c). During the time that midwifery services were suspended, women and their families who were in midwifery care at the time of the suspension were transferred to family physicians and obstetricians in that area for perinatal care, and no new clients were accepted into midwifery care.

The suspension of midwifery services in 2018 was not the first time that midwifery services were suspended or compromised in Nova Scotia (CBC News, 2010). Other sites in the province have faced staffing challenges which have also had impacts on the delivery of

midwifery services generally and the delivery of specific services that midwives offer, such as home birth (Mulligan, 2018).

The sustainability of midwifery in Nova Scotia has been an ongoing concern since the regulation and integration of midwives into perinatal health care services in 2009. This was documented in the government procured report (Kaufman et al., 2011) conducted by an external assessment team in 2011, two years following the regulation and integration of midwives at three model sites in Nova Scotia.

The sustainability of midwifery, and the challenges that midwives are facing to ensure the sustainability of midwifery services can also be seen across Canada. For example, in Saskatchewan, researchers identified a small number of midwives working within the province and a need for human health resource planning for midwifery (Hanson & McRae, 2014). In a study by Stoll and Gallagher (2018), 158 midwives in the provinces of Alberta and British Columbia were surveyed and ninety-nine (64%) of the midwives reported that they had considered leaving midwifery in the past year. The midwives in the study identified their top three occupational stressors as; a work load that was too high or not enough time off (64.6%), conflicts with other health care provider colleagues (42.4%), and conflicts with other midwifery colleagues (39.2%) (Stoll & Gallagher, 2018). In a qualitative case study that explored the barriers and facilitators of midwifery implementation in Manitoba, researchers (Thiessen, Heaman, Mignone, Martens, & Robinson, 2016) described midwifery as a “precarious profession” (p. 12), which reflected an overall lack of professional capacity related to; recruitment and retention challenges, challenges with the model of employment, lack of midwifery access in rural and remote areas, and the high demands on a profession which is small in numbers. More recently, the Midwives Association of British Columbia has started a

campaign to raise public and political awareness for more support and investment in midwifery services in that province due to the need to improve access to midwifery services and the high demands for midwifery care (Midwives Association of British Columbia, 2018).

There is also a global discourse about the sustainability of midwifery as a profession and the sustainable distribution of midwifery services within health systems. According to a report by the World Health Organization, where 2470 midwifery personnel from 93 countries were consulted through a workshop and an online survey, there were nine barriers to midwives' ability to provide quality perinatal care (2016b). The nine barriers were; a) unequal power relations and gender inequality, b) lack of security, unsafe working conditions, and social isolation, c) limited organizational power and solidarity with others, d) lack of adequate midwifery education and professional development, e) poor overall midwifery human resource management and policies f) health system issues (such as lack of resources, medical hierarchy, role clarity) that limit delivery of quality midwifery care, g) lack of regulation and accreditation, h) insufficient salaries when compared to similar professions i) social, legal, and regulatory contexts that reinforce poor perceptions of midwifery and gender inequality (World Health Organization, 2016b). Although the contexts in which midwifery is practiced globally are varied, midwives are experiencing many of these barriers in similar ways, and midwives in Nova Scotia face many of these barriers. This situates the sustainability and capacity challenges for midwifery in Nova Scotia within a larger global conversation about gender and the value of midwifery, mothers, and newborns.

In the same World Health Organization (WHO) report (2016b), which explored the realities that midwives face in their midwifery practices around the world, midwives offered their reflections of what had already improved their working conditions. The midwife participants reported the following examples of improvements to their work as midwives; increasing the

number of midwives, training and professional development, midwife-led models or midwife group practices, collaboration with other personnel to assist with less specialist tasks, pay equity and increases in pay, and improved supervision and management (World Health Organization, 2016b). These midwives' reflections of what has worked to improve the working conditions are not surprising when we compare them to the list of barriers identified in the same report. These examples of improvement offer us direction in how to focus our efforts to build sustainable midwifery services in Nova Scotia and globally.

Midwives and nurses in this study who had previously worked together were provided with an opportunity to build on existing collaborative relationships, in a new context that was away from the institutional setting of hospitals, as a result of the introduction of the RN Second Attendant role. The midwifery and nursing professions were flexible to negotiate the terms of this new nursing role, with the aim of providing sustainable home birth services to people in midwifery care. At a professional level, both midwives and nurses reflected, what participants in this study experienced as, an ongoing negotiation of roles and a decided comfort with the crossover of skills and practices, as seen in the theme "Negotiating roles and practices: 'Every nurse is different, every midwife is different, every birth is different.'"

This was exemplified in the professional collaboration required to create the RN Second Attendant policy (Midwifery Regulatory Council of Nova Scotia, 2017a) and the position statement about RN Second Attendants (College of Registered Nurses of Nova Scotia, 2015), as well as the implementation of the RN Second Attendant Program. This created a foundation to support collaboration between midwives and nurses at the provider and system levels.

The need to provide sustainable midwife-attended home birth services at the three model sites in Nova Scotia stimulated the creation of the RN Second Attendant role. The response to

this need required an innovative approach which has not been fully explored or implemented in other Canadian jurisdictions. For example, until July 2018, Ontario births in the care of a midwife were mandated to be attended by two midwives regardless of whether the birth occurred in the hospital, at home, or in a birth centre (College of Midwives of Ontario, 2018b). In Nova Scotia, midwifery births were mandated to have one midwife in attendance and either another midwife or a second attendant (Midwifery Regulatory Council of Nova Scotia, 2017a). This meant that from the beginning of midwifery integration in Nova Scotia, midwives and nurses had to work together in the hospital. Therefore, the introduction of RN Second Attendants attending home births with midwives as a means to address the lack of sustainability in home births became an extension of existing collaborative midwife and nurse relationships.

Often, innovative collaborative approaches to the delivery of health care have been created in response to health care needs within a context of systemic, community, or individual challenges. Examples in which innovation was the response to the challenges of delivering sustainable perinatal care include; the introduction of a dedicated home birth team at a hospital in the United Kingdom, staffed by midwives and midwifery support workers who attend home births together as an innovative approach to increase home births services in that district (Taylor, Henshall, Goodwin, & Kenyon, 2018). In another example, a strategy to address the shortage of midwives in rural areas in Australia included the introduction of dual nursing and midwifery roles, where, upon completing dual degrees, a health professional could hold licenses to practice nursing and midwifery (Yates, Usher, & Kelly, 2011). Both of these examples were faced with challenges in the implementation and sustainment of the programs; in the example from the United Kingdom it was challenging to recruit and retain midwifery support workers and the midwives were reluctant to work with the midwifery support workers as they worried that the

midwifery profession would be eroded due to a reliance on another type of provider with similar skills (Taylor et al., 2018). In the Australian example, burnout was a concern and midwives who worked in dual roles as both a nurse and midwife in rural areas were often consumed with nursing work, having less opportunities to engage in midwifery work, this created a concern that midwifery skills would be lost over time (Yates et al., 2011). These examples demonstrate efforts to address maternal and newborn health care needs in innovative ways in an effort to sustain midwifery services in challenging contexts. This further illustrates that there are many shared challenges globally in building sustainable midwifery services.

Establishing sustainable midwifery services in Nova Scotia has required midwives and nurses to be innovative in the ways that they collaborate. Building sustainable midwifery in Nova Scotia has required a negotiation of their roles, comfort in the crossover of practices, and ongoing communication between both midwives and nurses at individual and professional levels. This has created a solid foundation for future collaborative innovations between midwives and nurses in Nova Scotia to ensure that sustainable midwifery services are accessible to families throughout the province.

## **6.2 Midwives, Nurses, and Hegemonic Medical Discourses**

In this study, the midwives and nurses in Nova Scotia often talked about their beliefs, values, and practices in relation to their acceptance of or resistance to the historically polarized midwifery and medical discourses, this was illustrated in the theme “Reconciling systemic tensions: The medical model and the midwifery model.” When midwives and nurses collaborated in Nova Scotia, they often challenged the dichotomy of the midwifery and medical discourses, this was evident in how they protected their collaborative relationships, maintaining the (in)visibility of their collaborative activities. The participants were aware of the dichotomy

between medical and midwifery discourses and they variably accepted and resisted the institutional expectations that were aligned with the hegemonic medical discourses. . The historical alignment of nursing with the hegemonic medical discourses and the marginalisation of midwifery discourses, provided an interesting context for this study, given that the findings were generally positive in terms of how midwives and nurses collaborated in Nova Scotia.

The historical dichotomy and the polarization between midwifery and medical discourses of perinatal care, illustrated in the findings of this study, is not new and has created siloes of health care providers making collaboration difficult (Newnham, 2014). Newnham argued further in her exploration of knowledge and power in birth that, “The dichotomy between midwifery and obstetric models is damaging; to women, to midwives, and possibly to obstetrics,” (2014, p. 264). Researchers in Australia identified how the dichotomy between a social model of care associated with midwifery, and the surgical model of care associated with medicine, has had clinical implications related to how care providers have historically practiced regarding the care for the perineum during birthing (Dahlen, Homer, Leap, & Tracy, 2011). In the social (midwifery) model, care providers have historically not interfered with the perineum during birth, instead providing comfort measures like warm compresses (Dahlen et al., 2011). In the surgical (medical) model, care providers often intervened with surgical interventions such as episiotomies regarding the perineum as a surgical site (Dahlen et al., 2011). The implications of this dichotomy of discourses does not rest in the realm of ideology or philosophy, the dichotomy also has clinical and health implications.

More recently, we can see evidence of this ongoing dichotomy between midwifery and medicine, when we examine how research is conducted and positioned. The way that research is conducted, further polarizes midwifery and medicine because much research examining

midwifery care, services, or practices is conducted with standard (medical) approaches as the comparison. For example, researchers have compared; freestanding midwifery units with obstetric units (Overgaard, Fenger-Grøn, & Sandall, 2012), birth outcomes of women who have received prenatal care from a physician versus a midwife (Loewenberg Weisband, Klebanoff, Gallo, Shoben, & Norris, 2018), and maternity outcomes of women who received midwifery-led care versus physician-led care (Thiessen, Nickel, et al., 2016). Comparative research is needed to improve our understandings of practices, contexts, and associated outcomes, but we need to consider how this research reinforces existing dichotomous understandings of midwifery and medical discourses.

### **6.2.1 Historical and contemporary midwifery discourses.**

In Canada, midwifery discourses have historically been located at the margins of health care because midwifery was excluded from mainstream perinatal care until its regulation began more than twenty years ago (Bourgeault, 2000, 2006; Plummer, 2000; Relyea, 1992). Bourgeault (2006) described how midwives worked in obscurity, often in small religious communities, in rural and remote areas, and quietly away from mainstream medicine, until its re-emergence in the late 1970s and 1980s and regulation in the early 1990s. Plummer (2000) and Relyea (1992) also wrote about the historical marginalization of midwifery in Canada, as described earlier in the literature review. Although there is not a universal history of midwifery (Biggs, 2004) in Canada over the past two centuries, there are historical patterns of its exclusion and marginalization across the country. The exclusion and marginalisation of midwifery from the dominant medical system is not unique to Canada. Newnham (2014) described how midwifery knowledge has a history of being ‘marginalized, displaced, and labelled as ‘unscientific,’ (p.257). The exclusion

from the dominant health care system meant that midwives, midwifery practices, midwifery knowledge, and midwifery discourses have not been largely visible.

With the historical exclusion of midwifery from the mainstream health care system in Canada, midwifery practices, and the values and beliefs that informed these practices, remained at odds with hegemonic medical practices. As midwives, women, families, and communities prepared for the regulation of midwifery, they identified and articulated the beliefs, values, and practices that were common and important to midwives and the people they served (Bourgeault, 2006). Once identified, the beliefs, values and practices were formalized and have informed the core competencies for midwifery in Canada (Canadian Midwifery Regulators Council, 2018b) and the Canadian midwifery model of care (Canadian Association of Midwives, 2015b).

There are six Canadian core competencies for midwives in Canada according to the Canadian Midwifery Regulators Council (2018b); pregnancy and birth as normal physiological processes, informed choice, autonomy of midwives, continuity of care, birth setting, and evidence-based practice. These competences reflect midwifery values and beliefs about birth and midwifery in Canada, and have shaped various discourses which can be categorized as midwifery discourses. Examples of midwifery discourses that were discussed in this study included; pregnancy and birth as normal life processes, safety of home birth, low/no interventions unless required, woman-centered care, choice of birth place, informed consent, continuity of care, flexibility, communication, non-hierarchical relational care, and midwives as primary care providers. When compared to the Canadian core competences listed previously, we can see the similarities between the midwifery discourses identified in this study and the values and beliefs of Canadian midwifery which inform the discourses associated with a larger midwifery discourse.

### **6.2.2 Nurses and the history of hegemonic medical discourses.**

There was a historical pattern of alliance between nurses and physicians in Canada (Bourgeault, 2006; Plummer, 2000; Relyea, 1992), and in other places, such as Australia (Newnham, 2014) and the United Kingdom (Hallett & Fealy, 2009; MacMillan, 2012; Voyer, 2013), which ensured nurses' integration into what has become the hegemonic system that delivers health care. This historical alliance meant that nurses were endorsed by physicians and integrated as credible and trusted professionals within the mainstream health care system. The historical positioning of nurses within the health care system and midwives outside the health care system created a historically tension-filled relationship between nurses and midwives in Canada (Benoit, 1991; Bourgeault, 2006), where the female dominated profession of nursing was included and the female dominated midwifery was excluded (Adams & Bourgeault, 2004). Historically, the organization and operation of the health care system, has been influenced by medical discourses that originated from the beliefs and values of physicians and the medical profession (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010; Newnham, 2014). Medicine has historically been a male dominated profession where expertise relied with the male physician, whose chosen specialty indicated a hierarchy of both knowledge and authority with (female) nurses located lower in the hierarchy (Adams & Bourgeault, 2004; Hallett & Fealy, 2009), and patients located lower still.

In this study, examples of medical discourses included; birth as an illness and therefore a pathological or a medical event (Benoit et al., 2010), the hospital as the safest place for birth (Newnham, 2014), pregnancy and birth as inherently risky (Newnham, 2014), guidelines & policies are needed for standardized care (Newnham, 2014), nurses as supportive or complementary to physicians (MacMillan, 2012), hierarchy of care where the physician is at the

top of the hierarchy (Benoit et al., 2010; MacMillan, 2012). Many of these discourses, categorized as medical discourses, have dominated mainstream understandings of pregnancy, birth, and the postpartum period (Newnham, 2014). Nurses have worked within the health care system, and as midwives have been integrated into this system, dominated by medical discourses, both professions have had to negotiate any tensions that are created when their values and beliefs about perinatal care do not align within a patriarchal and hierarchically designed system.

### **6.2.3 Intersections and (in)visibility of collaboration between midwives and nurses.**

Prior to midwifery regulation, midwives worked within the community and mostly in the homes of the people they served (Biggs, 2004; Plummer, 2000; Relyea, 1992). This made the work that midwives did prior to regulation invisible, unless emergencies occurred and transfer from home to hospital occurred (MacDonald & Bourgeault, 2009). These situations, where midwives sought assistance in emergency situations, reinforced the privileging of medicine over midwifery, as a safer and optimal option for perinatal care because these intersections between midwives and health care providers were often the only experiences that health care providers had with midwives and midwifery. Nurses, who often present for the admission of women to hospital for emergent perinatal care, believed these emergent situations or negative outcomes were a result of midwifery, and this reinforced their beliefs about birth and birthing based on medical discourses (Kornelsen & Carty, 2004; MacDonald & Bourgeault, 2009).

The introduction of midwifery to nurses and other health care providers at the three model sites in Nova Scotia has provided midwives and nurses with an opportunity to work together as colleagues, instead of competitors. Although it was not without some challenges initially (Kaufman et al., 2011), the foundation for collaboration between these professions was

created with the introduction of midwives as primary health care providers who were expected to work with nurses during hospital births. This foundation for collaboration was further enhanced by the RN Second Attendant program, with nurses attending home births with midwives. This has provided nurses with an opportunity to collaborate with midwives in a new context and away from the institutional setting of the hospital. Interestingly, even with the integration of midwives into the hospital setting, and the integration of nurses into home birth settings, the findings from this study suggest that collaboration between midwives and nurses may be (in)visible to other health care providers.

The (in)visibility of collaboration between midwives and nurses in this study may echo the historical invisibility of midwifery prior to regulation. Nurses collaborating with midwives at births are exposed to births that generally do not involve specialists, unless there is concern about an aspect of the birth, and so in a birth attended by a midwife and a nurse, those two health care providers may be the only professionals involved in a low-risk birth. Midwives consult or transfer to an obstetrician if something out of the ordinary was happening or anticipated to happen based on established criteria (Midwifery Regulatory Council of Nova Scotia, 2017b). As such, other health care providers do not have the same exposure to a midwife-attended low-risk birth, because their services are required only for high-risk situations. This may contribute to the (in)visibility of collaboration between midwives and nurses, as most midwife-attended births are low-risk with little or no interventions. Also, while midwives have been integrated into the health care teams at the three model sites, they are still very few in number, and their small numbers have contributed to their lack of public and professional visibility.

The other interesting aspect of the (in)visibility of collaboration between midwives and nurses is one participant's (Florence's) observation that collaboration between these two

professions was a ‘best kept secret’. She talked about how midwives and nurses at the model site where she worked protected the secret of their collaboration. This leaves us with further questions about what they are protecting – the collaborative relationships? Their collaborative practices? An environment that supports normal birth? This is similar to what Fahy and Parratt (2006) referred to as ‘midwifery guardianship’. Midwifery guardianship “involves guarding the woman and her Birth Territory; this entails nurturing the woman’s sense of safety through the respect of her attitudes, values, and beliefs,” (Fahy & Parratt, 2006, p. 47). For Fahy and Parratt, ‘midwifery guardianship’ is about midwives protecting the birthing space in order to ensure that the birthing woman is not disturbed or threatened during her birth. In this study, the midwives and nurses were collectively protecting the birth space for the birthing woman, and they were also guarding their collaborative practices and relationships based on their shared values and beliefs about birth as health care providers. This meant that the ways that midwives and nurses collaborated were kept secret, and reinforced the (in)visibility of their collaborative practices and relationships within the larger medical institution.

#### **6.2.4 Gender, inclusion, and marginalization.**

Both the nursing and midwifery professions have been historically dominated by women (Adams & Bourgeault, 2004). Nurses were integrated into the medically dominated health care system in a supportive role to physicians. Nurses provided ‘care’ to the ill and infirm, and caring has been historically categorized as a ‘feminine’ attribute and nursing a role for women (Treiber & Jones, 2015; Voyer, 2013). Midwives were excluded from the medical health system and maintained their autonomy because they were not governed by the medical system. Nurses’ roles (beliefs and values) were largely defined by or in relation to physicians (Kornelsen & Carty,

2004; MacMillan, 2012), and historically hegemonic medical discourses. Midwives, on the other hand, defined their own roles (beliefs and values) in relation to the people they served.

Midwives faced many challenges associated with their marginalization from the mainstream health care system, but they were also afforded certain freedoms such as autonomy over their practices until their regulation (Plummer, 2000; Rooks, 1997a). Exclusion from the dominant medical system and the medical discourses that influence care meant that midwives were not governed by medicine. Their feminist position was located ‘with women’ and outside of the patriarchy and hierarchies embedded in the dominant medical health care system (Adams & Bourgeault, 2004). Nurses had to negotiate authority from their position within the medical institution (Hallett & Fealy, 2009) and therefore did not have the same freedoms that midwives had because their practices and profession were governed by the health care system which sustained medical discourses. The feminism of nursing was located within patriarchal and hierarchical medical discourses (Adams & Bourgeault, 2004). Often this meant that nurses had to “work around the margins of authority” (Hallett & Fealy, 2009, p. 2682) in order to determine their own practices.

Although both professions have articulated feminist values at different times, their historical contexts and discourses located within those contexts further shaped how those perspectives were situated and enacted. Some authors suggest that differing feminist perspectives between the professions sustained the historical tensions that they experienced, divided them as providers, rather than uniting them as feminists (Adams & Bourgeault, 2004). In this study, the participants challenged our notions of this tension, illustrating collaborative experiences situated amongst larger discourses, but supported by shared beliefs and values. The findings also provide

hope for the construction of new, more gender inclusive discourses, models, and systems of health care which support collaboration.

### **6.2.5 Historical orientation of nurses within medical discourses.**

Nurses have predominantly experienced and been exposed to birth in Canada within a medical system, influenced by hegemonic medical discourses. However, many nurses have also been socialized within a holistic nursing discourse in which a holistic approach to care is valued and embraced (Owen & Holmes, 1993). A holistic nursing discourse which values clients as individuals with various internal and external influences on their health, and holistic approaches to care which integrate mind, body and spirit (Owen & Holmes, 1993) aligns with midwifery discourses such as the discourse that values pregnancy and birth as normal processes. This discord that some nurses face, between traditional medical discourses and a nursing discourse that values holistic approaches to care, positions nurses to engage with midwives and midwifery practices because of shared values of inclusive, individualized, respectful care.

In his study, nurses who worked at the three model midwifery sites in Nova Scotia, practiced in between the discourses of midwifery and medicine, because they engaged with health care providers who were often strongly aligned with one discourse or another. Nurses straddled this dichotomy of two discourses as they worked with providers and clients who had a variety of beliefs and values within an overarching system, which privileges a medical discourse. This positioning of nurses, as trusted, integrated members of the health care system who have the flexibility to work within polarizing contexts governed by midwifery discourses and medical discourses, is unique to Canada, and perhaps more so it is unique to Nova Scotia, where the sustainability of midwifery has depended on collaboration between nurses and midwives. Nurses are well-situated to challenge and transform current and historical dichotomies between medical

and midwifery discourses, and instead advocate for a person-centred discourse, which values inclusion, respect, collaboration, and flourishing for all persons.

### **6.3 Person-centred Care**

In this study, relationships between midwives and nurses were important for their ability to collaborate with each other and to support women throughout their perinatal journeys. Discourses of person-centred care were reflected in the theme “Sustaining relationships: ‘The more we can just build relationships with one another.’” Unique to the collaboration between midwives and nurses in Nova Scotia is the positioning of nurses as Second Attendants for home births. This program has exposed nurses to midwifery philosophy away from the dominant hospital institution, and created opportunities for nurses to see birth in different contexts, with different resources, and fully informed by midwifery discourses and a midwifery philosophy of care. Together, they created respectful, inclusive spaces for each other at home births and at hospital births. Under these circumstances, the midwives and nurses often worked within a discourse of person-centered care (McCormack & McCance, 2016), in which the client and the family receiving care were the focus, but created a respectful and inclusive space for the relationships between midwives and nurses. The space allowed midwives and nurses to be authentic in their relationships with all the persons involved at each birth. They recognized their shared values and beliefs, which allowed them to negotiate their practices respectfully in order to honour the meaningfulness of the birth each for the women and families they served and for each other.

The person-centred care framework was initially developed by nurses in the United Kingdom who explored ways to engage in nursing care for people with dementia in a dignified, respectful, and meaningful way (McCormack & McCance, 2016). Over the past decade, the

discourse of person-centered care has grown, informed by new research which has supported its application in numerous contexts, places, and spaces (McCormack & McCance, 2016). From person-centered moments, to person-centered cultures, a person-centered care framework enhances the practices of care providers and recipients alike, so that all persons involved in health care are included, respected, and healthy as they work together to optimise the health of an individual, family, or community. According to McCance and McCormack (2016), person-centredness is,

“... an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.” (p. 60)

In many ways, person-centred care is an umbrella concept, under which are positioned woman centred care, family centered care, and patient centred care (E. Snelgrove-Clarke, personal communication, November 8, 2018). Person-centred care expands these important perspectives to more broadly include all persons involved in a service user’s care (McCormack & McCance, 2016). It values and creates space for relationships between all persons involved in a service user’s care. This differs from other approaches in health care, where the focus is on the individual relationships between care providers to services user(s). For example, in a recent concept analysis conducted by Fontein-Kuipers, deGroot, and Van Staa (2018), woman-centered care was defined as,

“.. a philosophy and a consciously chosen tool for the care management of the childbearing woman, where the collaborative relationship between the woman – as an

individual human being – and the midwives – as an individual and profession – is shaped through cohumanity and interaction; recognizing and respecting one another’s respective fields of expertise. Woman-centered care has a dual and equal focus on the women’s individual experience, meaning and manageability of childbearing and childbirth, as well as on health and wellbeing of mother and child. Woman-centered care has a reciprocal character by fluctuates in equality and locus of control.” (p.8)

The woman-centered approach for perinatal care has been historically positioned as a feminist response to the medicalization of women’s reproductive health care (Morgan, 2015). Midwifery has had a history of being woman-centered, and by extension woman-centered care has often been associated with the values and practices of midwifery (Morgan, 2015). Within the midwifery philosophy of care, women are centered as primary decision-makers for informed choices in relation to their bodies, babies, and births (Canadian Association of Midwives, 2015b). The primary relationship of focus is between the midwives (primary care provider) and the woman (service-user), and the woman (service user) is the primary decision maker in woman centered care.

According to national guidelines produced by the Canada Public Health Agency regarding family-centered maternity and newborn care,

“Family-centered maternity and newborn care (FCMNC) is a complex, multidimensional, dynamic process of providing safe, skilled and individualized care. It responds to the physical, emotional, psychosocial and spiritual needs of the woman, the newborn and the family. FCMNC considers pregnancy and birth to be normal, healthy life events and recognizes the significance of family support, participation and informed choice.” (Chalmers et al., 2017, p. V)

In family-centred care, specifically as it relates to maternal and newborn care, the needs of the woman and her family are the center of care. This approach is holistic in the sense that it acknowledges that all aspects of a person and their family are important for their participation and decision-making during their care. An American doctoral prepared nurse named Celeste Phillips, advocated for family-centred care throughout her career spanning the 1970s-1990s (Zwelling, 2000) and published her work about family-centered care and the principles that inform that approach (Phillips, 2003). A Canadian physician, Dr. Murray Enkin was another early advocate for family centered care. Enkin (1973) believed that families should be involved in maternity care and advocated for the participation of fathers in labour and birth, as well as making rooming-in available to new mothers. Again, in this approach to care, the primary relationship is between the primary care provider and the family and the whole family is included in decision-making.

According to the Institute of Medicine (2001) patient-centered care is defined as, “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Patient-centered care, in this definition includes the patient and responds to the patient’s needs, values and preferences, however it does not mention the service-user’s family or relationships with care providers. It also reaffirms notions of illness, with references to the service-user as a ‘patient’ which is generally inappropriate for most service-users requiring perinatal care. Patient-centered care was established by physicians within the dominant medical discourses, as a way to improve inclusion and participation of patients receiving care, ensuring that their values and opinions were included in care plans (Stewart, Brown, Weston, Freeman, & McWilliam, 2014). In this approach to care,

the primary relationship is between the care provider (physician) and the patient. The physician is the primary decision-maker but the patient's needs and values are taken into consideration.

In each of these definitions, the service user(s) are central and the focus on individual relationships between care providers and service users rather than collective relationships amongst all persons involved. In woman-centered care, there is an effort to reorient health care from the patriarchy of the traditional health system to an approach that is empowering and welcomes women to participate equally in their health care. In family centered care, there was an effort to recognize that health care extends to all members of a service-users' family who are involved and affected by changes in health status of that service user. In patient-centered care, there was an effort to recognize the patient as a person with values and individual needs, and not just the pathology of their disease process. Person-centered care embraces all of these approaches and shifts our efforts towards a collective, relational engagement with everyone involved in a service user's experience. Person-centeredness opens space where the values, beliefs, and practices of persons are respected, leading to mutual, authentic engagement between persons and laying the groundwork for all to flourish (Dewing & McCormack, 2016).

The experiences of collaboration between midwives and nurses in this study were exemplars of person-centredness. The participants described experiences where collaboration between midwives and nurse illustrated moments of person-centredness (Manley, 2016) which extended to hours of person-centredness over the course of their collaboration during births. According the Manley (2016), person-centred moments are the beginning of a person-centred continuum in the development of person-centred cultures of practice for individuals and teams. Their openness to negotiate their roles in recognition that they shared many skills and practices highlighted how they navigated issues of trust and dependence. Midwives and nurses in Nova

Scotia are leaders in person-centered care in the ways that they used communication to identify each other's values and beliefs, including their preferences for practices. They created safe birthing spaces for women and their families, as well as for their own relationships with one another. Participants also talked about how collaboration between midwives and nurses was changing the culture at the medical institutions where midwives and nurses worked.

Nova Scotia health care is ready for person-centred approaches, particularly with regards to the delivery of primary health care services, of which perinatal care generally, and midwifery care specifically, are systemically located. In a document created by the Nova Scotia Health Authority (2017) to guide efforts for the strengthening of primary health care in Nova Scotia, person-centred care was listed as the first element required for the delivery of primary care. Interest in the integration of person-centredness and person-centred cultures in health care is growing globally, as a response to the need for more comprehensive, relational-based health care. According to McCormack and McCance, (2016), person-centredness has informed health policies at different organizations in; the United Kingdom, Norway, Denmark, the United States, and Canada. Person-centred care also aligns with the larger agenda of the World Health Organization, which aims to provide health care in health systems that locate people centrally in the delivery of health services, referring to this approach as 'people-centred' (McCormack & McCance, 2016; World Health Organization, 2015).

With the integration of midwifery in Nova Scotia, nurses at the three model sites have experienced an alternate approach to birth, which aligns with a nursing value of holistic health care approaches. The person-centered care framework (McCormack & McCance, 2010), embodies the value of holism in health care. It also has the potential to unify midwives, nurses, and other perinatal health care providers when we conceptualize it as an umbrella for the other

approaches to care previously discussed. This unification, under person-centeredness, presents the possibility of minimizing the polarity between medical and midwifery discourses, and provides transformative potential for new, innovative, collaborative midwife and nurse led models of perinatal care.

#### **6.4 A New Collaborative Model of Care**

In this study's theme "Moving forward: A modern model for nurses and midwives working together," many participants talked about creating a new model of care based on their experiences or knowledge of collaboration between midwives and nurses in Nova Scotia. Participants shared how the culture of provided perinatal care was changing with the introduction of midwifery and nurses collaborating with midwives in home and hospital births. Participants in this study also identified a need for increased advocacy for great understanding and equitably distributed midwifery in Nova Scotia, specifically nurses were identified as having the potential to be advocates for midwives and midwifery in the province. These findings were positioned within the context of a discourse of unsustainable midwifery services which were inequitably distributed to women and families throughout the province (Smith, 2017). Families in Nova Scotia have also been affected by a province-wide shortage of physicians (Doctors Nova Scotia, 2018). As of September 2018, there were more than 50,000 Nova Scotians who did not have access to a family physician (Nova Scotia Health Authority, 2018a) or Nurse practitioner for primary health care. Primary health care responds to health and wellness across the lifespan of an individual, including birth and death (Nova Scotia Health Authority, 2017). Midwives are expert primary health care providers for woman with low-risk pregnancies and birth (Association of Nova Scotia Midwives, 2018). With women and families lacking access to primary health care generally, not enough midwives, and no documented government vision for or commitment to

the expansion of midwifery services in the province, it is necessary to raise awareness about the benefits of midwifery care for families, providers, and the health care system. It is also important to highlight how a collaborative model led by midwives and nurses could address and improve the landscape of Nova Scotian birthing care and primary care, for stakeholders and decision-makers in Nova Scotia.

The benefits of midwife-led, continuity of care models of perinatal care, where professionally prepared midwives (direct-entry midwives and nurse-midwives) are the lead or ‘in-charge’ health care provider, have been established (Medley, Vogel, Care, & Alfirevic, 2018; Sandall et al., 2016) and have been recognized by the World Health Organization which issued a global recommendation for midwife-led models of care for women during the perinatal period (2016c). Midwives and nurses have also been identified for their position and potential to address inequities in the delivery of health care generally, specifically as it relates to the attainment of universal health coverage (Crisp, Brownie, & Refsum, 2018; World Health Organization, 2016a). Global efforts are underway to raise the profile and to strengthen nursing and midwifery around the world (Burdett Trust for Nursing, 2018; Crisp et al., 2018; World Health Organization, 2016a).

Closer to home, in a position statement about the Canadian midwifery model of care, the Canadian Association of Midwives articulated their support of “collaborative care that is innovative and midwifery led” (2015b, p. 2). In their position statement about their commitment to collaborative care, Canadian midwives and nurses articulated the need for “increasing the development of interprofessional and collaborative models for health service delivery as important for improving access to primary maternity care.” (Canadian Nurses Association et al., 2011). This is different from other countries globally because in Canada, midwives and nurses

are two separate professions. The need for collaboration between health care providers for the delivery of primary health care was highlighted in the Nova Scotia Health Authority's document (Nova Scotia Health Authority, 2017) for the delivery of primary health care, however midwives were excluded from the suggested composition of family practice teams (Nova Scotia Health Authority, 2017). This leads to questions about; the continued marginalization of midwifery in Nova Scotia, ongoing miss-understandings of midwifery, and why midwifery care continues to be under-used and under supported, despite clear evidence of the excellent outcomes related to midwifery care.

A collaborative midwife and nurse led model of perinatal care aligns with the priorities established in the Nova Scotia Health Authority's synthesis about the (Nova Scotia Health Authority, 2017) delivery of primary health care. Positioning a collaborative midwife and nurse led model of perinatal care as an extension of the primary health care model that the Nova Scotia Health Authority offers, would require the same elements identified as necessary for the delivery of primary health care. The elements are; person-centeredness, community oriented, accessibility, comprehensive team approach, comprehensive and integrated care, meeting the service user where they are in their health and wellness journey (Nova Scotia Health Authority, 2017). As an integrated model of care, a collaborative midwife and nurse led model would maintain current arrangements, between midwives and other health care providers, for consultations and transfers of care to specialists when appropriate (Midwifery Regulatory Council of Nova Scotia, 2017b), however the model would provide care to persons considered to be low-risk.

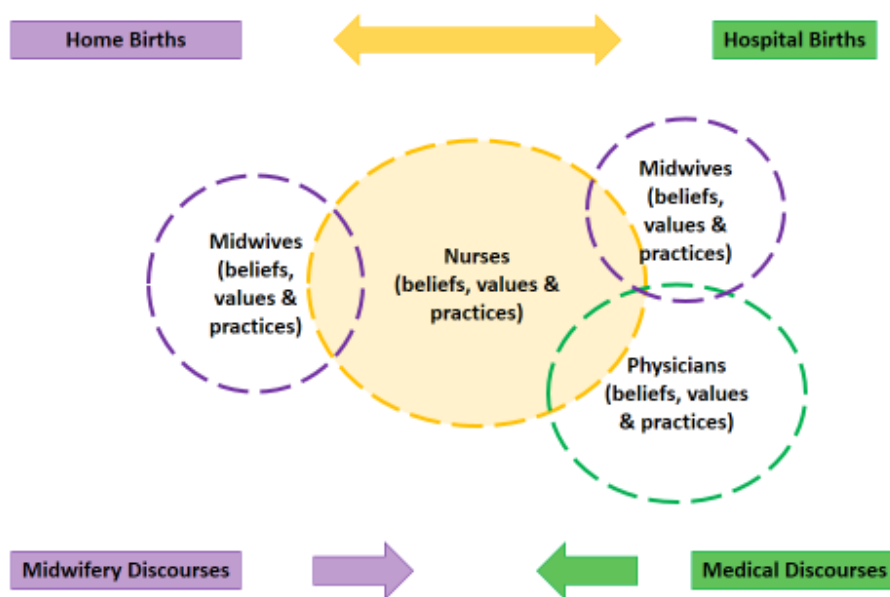
This leads to the question of what a collaborative midwife and nurse led model of perinatal care might look like. The collaborative midwife and nurse led model for perinatal care

would be embedded in a person-centered culture that embraces therapeutic and compassionate relationships between service users and providers, between providers, and between all persons involved in a course of care (Manley, 2016). The person-centred culture would provide a safe space for midwives and nurses to engage in a constant negotiation of their roles and practices, sustain their relationships, and aim to reduce polarity between midwifery and medical discourses. Collaboration would be understood and engaged with as a dynamic process that involves elements of “sharing, partnership, interdependency and power,” (D’Amour et al., 2005, p. 118). The core competencies of the Canadian midwifery model of care would guide the philosophical approach to care and include; respect for pregnancy and birth as normal physiological processes, informed choice, midwives as autonomous care providers, choice of birth place, continuity of care, and evidence-informed practices (Canadian Midwifery Regulators Council, 2018b). The collaborative midwife and nurse led model of perinatal care would be available to all birthing persons deemed to be low-risk, and would be well integrated into the whole perinatal health care team in terms of appropriate screening, consultation, and transfers as necessary. This model would also accommodate other health care providers and maintain a flexibility to be both responsive to the needs of birthing persons and lead innovative approaches to evidence-informed practices throughout the continuum of the perinatal period.

A collaborative midwife and nurse led model for the delivery of perinatal health care to low-risk populations would effectively ‘flip the switch’ in perinatal health care. This model would re-orient perinatal care from its historical origins within a patriarchal system supported by a medical discourse, to a person-centered model led by two health care professions who have historically been female dominated. Nurses are positioned to cross-pollinate the values and practices of midwifery (see Figure 3) and to help integrate this new model into the existing

system because they collaborate with and have ongoing relationships with midwives, physicians, and service users, in hospitals and in homes. Nurses also straddle both midwifery and medical discourses of perinatal care, and this uniquely positions them to cross-pollinate the values, beliefs, and practices, which have been traditionally associated with either midwifery or medical discourses. This would also reorient historical maternal and newborn care away from a philosophy that pregnancy and birth are medical events, where every woman needs to be in the care of a physician, to one where, “Every woman needs a midwife, and some women need a doctor too,” (Sandall, 2012, p. 323).

Figure 3 Nurses as cross pollinators of midwifery values and practices



A collaborative midwife and nurse led model of perinatal care also aligns with the Framework for Quality Maternal and Newborn Care (Renfrew et al., 2014). The framework was developed by researchers who conducted three systematic reviews which examined; women’s experiences and views of maternal and newborn care, the effectiveness of practices in maternal and newborn care, and the characteristics and effect of midwives and other health care providers

providing some or all components of midwifery care (Renfrew et al., 2014). The results of these systematic reviews were then used to create a maternal newborn care framework with an emphasis on support and prevention, and appropriate transfers for women and infants with complications (Renfrew et al., 2014). Within the context of this framework, midwives and nurses working together in a collaborative model are positioned to provide leadership for a system-level transformation.

### **6.5 Implications for Research, Policy, Education, and Practice**

Sustaining a new collaborative midwife and nurse led model of perinatal care will require a long term vision and strategic plan for midwifery services in Nova Scotia. This study provides evidence that midwives and nurses are having positive experiences of collaboration, and are interested in creating a new model of perinatal care that builds on this foundation of collaboration. With political support and appropriate funding, the proffered collaborative midwife and nurse led model of perinatal care has the potential to position midwives and nurses in Nova Scotia as leaders in a person-centered, innovative model of perinatal care in Canada and globally. In order to move forward with this agenda, I offer the following visionary ‘to do list’, influenced by the recommendations of the Kaufman et al. report (2011):

1. Stabilize midwifery services at 3 model sites - This would include strong efforts for the recruitment & retention of midwives, the creation of a provincial role to oversee the midwifery program, raising the profile of midwifery and collaboration between midwives and nurses amongst health care providers and the public.
2. Expand midwifery services using the collaborative midwife and nurse led model of perinatal care throughout Nova Scotia – This would include human health resource planning, education for nurses and health care providers in midwife-unfamiliar areas,

orientation of midwives and to new jurisdictions, providing formal and informal opportunities for midwives, nurses, and other health care providers to build relationships, public campaign (supported by nurses) to raise awareness and understanding of midwifery and the collaborative midwife and nurse led model of perinatal care.

3. Develop an educational program for midwifery in Nova Scotia – This would include; a direct entry educational program for midwives, streamlined educational pathways and credentialing for nurses to become midwives (and vice versa), a certificate/diploma program the RN Second Attendant role, opportunities for inter-professional learning, teaching, and research.

Based on the findings from this study, I offer the following recommendations in the areas of research, policy, education, and practice (see Tables 10 – 13). The recommendations for research focus on; the need to further explore collaboration between midwives and nurses, how collaboration between midwives and nurses changes beliefs, values and practices, and the need to disseminate more evidence about midwifery and collaboration between midwives and nurses. The recommendations for policy highlight; the need for a comprehensive midwifery expansion plan in Nova Scotia; the need for sustainable midwifery services in Nova Scotia, and how a midwife and nurse led model of care could be implemented. The recommendations for education highlight a need to create a midwifery educational program in Nova Scotia which includes educational pathways for nurses and midwives, in midwifery and in nursing. Finally, the recommendations for practice illustrate; the need to create more opportunities for midwives and nurses to collaborate, a need to raise the public profile so that Nova Scotians (and clinicians) understand more about midwifery and the collaboration between midwives and nurses, and the need for nurses to advocate for midwives and midwifery in Nova Scotia.

Table 11 Recommendations for research

| <b>Recommendations for research</b>                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Explore collaboration between midwives and nurses in other jurisdictions in Canada.</li> </ul>                                                                                                             |
| <ul style="list-style-type: none"> <li>• Explore the integration and use of Second Attendants for home birth programs in other Canadian jurisdictions.</li> </ul>                                                                                   |
| <ul style="list-style-type: none"> <li>• Explore how working with midwives is changing nursing beliefs, values, and practices in perinatal care.</li> </ul>                                                                                         |
| <ul style="list-style-type: none"> <li>• Examine and evaluate low-risk models of perinatal care which are led by collaborative teams of midwives and nurses.</li> </ul>                                                                             |
| <ul style="list-style-type: none"> <li>• Examine how different birthing environments may influence nursing practice.</li> </ul>                                                                                                                     |
| <ul style="list-style-type: none"> <li>• Continue to disseminate information and evidence about midwifery services, collaboration between midwives and nurses, and innovative models of perinatal care that include nurses and midwives.</li> </ul> |

Table 12 Recommendations for policy

| <b>Recommendations for policy</b>                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Develop a comprehensive plan for the expansion of midwifery services throughout Nova Scotia which formally integrates and supports collaboration between midwives and nurses.</li> </ul> |
| <ul style="list-style-type: none"> <li>• Explore the feasibility of a midwife-led and nurse supported model of low-risk perinatal care.</li> </ul>                                                                                |
| <ul style="list-style-type: none"> <li>• Implement low-risk models of perinatal care which are led by collaborative teams of midwives and nurses informed by the person-centered care framework.</li> </ul>                       |
| <ul style="list-style-type: none"> <li>• Raise the public profile of midwifery, home birth, and for collaboration between midwives and nurses amongst the public and other health care providers in Nova Scotia.</li> </ul>       |
| <ul style="list-style-type: none"> <li>• Raise the public profile of Registered Nurses in the role of Second Attendants for home births amongst the public in Nova Scotia and in Canada.</li> </ul>                               |

Table 13 Recommendations for education

| <b>Recommendations for education</b>                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Create a midwifery education program in Nova Scotia to build capacity and ensure the sustainability of midwifery in Nova Scotia.</li> </ul>                                                                 |
| <ul style="list-style-type: none"> <li>• Explore possible innovative educational opportunities for nurses to be educated and/or oriented to the role of an RN Second Attendant for home births (post BScN diplomas, certificate program).</li> </ul> |
| <ul style="list-style-type: none"> <li>• Create educational pathways between nursing education and midwifery education to ease entry from one profession to the other.</li> </ul>                                                                    |

Table 14 Recommendations for practice

| <b>Recommendations for practice</b>                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Create more opportunities for midwives and nurses to build professional relationships (workshops, emergency skills training, policy/guideline development, rounds, etc..)</li> </ul> |
| <ul style="list-style-type: none"> <li>• Raise the public profile of midwifery and for collaboration between midwives and nurses amongst health care providers in Nova Scotia.</li> </ul>                                     |
| <ul style="list-style-type: none"> <li>• Raise the public profile of Registered Nurses in the role of Second Attendants for home births amongst nurses and health care providers in Nova Scotia and in Canada.</li> </ul>     |
| <ul style="list-style-type: none"> <li>• Explore and develop strategies for Registered Nurses to formally advocate for midwives and midwifery in Nova Scotia.</li> </ul>                                                      |

These recommendations reflect a need to more fully explore and support collaboration between midwives and nurses as an innovative strategy to ensure that midwifery and midwifery services are sustained and more fully integrated into maternal and newborn care in Nova Scotia. The recommendations reflect the existing global body of evidence and growing understanding that with appropriate supports, resources, and leadership, midwives and nurses are positioned to provide excellent, evidence-informed perinatal care. Several recommendations such as; creating a comprehensive plan for midwifery expansion and creating a midwifery education program, echo or build on previous recommendations made by Kaufman et al. (2011). The reason for the similarities is due to the lack of implementation of a comprehensive vision for the stabilization and equitable distribution of midwifery services in Nova Scotia over the past ten years.

## Chapter 7: Conclusions

The purpose of this study was to explore how midwives and nurses collaborate in Nova Scotia. Overall, collaboration between midwives and nurses in Nova Scotia is complex and it is influenced by a variety of social, historical, and institutional discourses. The challenges of sustaining midwifery and home birth in Nova Scotia have provided innovative opportunities for midwives and nurses to collaborate, such as having RN Second Attendants attend home births with midwives.

This study is important because it was the first study to explore collaboration between midwives and nurses in Nova Scotia. This case study addressed a clear gap in the literature. The findings are important when compared to three other Canadian studies that explored collaboration between midwives and nurses because they illustrated collaboration that was mostly working well, despite its occurrence within many systemic challenges. This is different from previous studies which highlighted tensions and interpersonal challenges in the ways that midwives and nurses collaborate.

This case study provided an opportunity for participants to share their experiences of collaboration between midwives and nurses within broader social and institutional contexts. Through their engagement in this research, the participants have loaned their voices to a global chorus of researchers, clinicians, and decision-makers who have identified a need to create more innovative and collaborative approaches for the delivery of perinatal health care services. It is inspiring to see collaboration between midwives and nurses in the delivery of perinatal health care, as a positive example of birthing care that works, emerge from the challenges of building sustainable midwifery services in Nova Scotia.

Despite the ongoing challenges of maintaining sustainable midwifery services in Nova Scotia, this is a good news story that reflects the voices and experiences of midwives, nurses, and other members of the perinatal team who have engaged with, been influenced by, or made decisions that impact collaboration between midwives and nurses in Nova Scotia. It also illustrates the great potential we have for building more collaborative teams of midwives and nurses in Nova Scotia and in Canada. With collaborative midwife and nurse led models of care, midwives and nurses in Nova Scotia have the potential to demonstrate leadership in a birthing model of care that works. There is a need for more research, leadership, government funding and support to implement this model of care across Nova Scotia and to disseminate and share what we have learned and created across Canada.

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## Appendix A: Characteristics of birthing care models that work

Authors of the book *Birth Models That Work* identified the following 23 characteristics in birthing care models that work:

- A woman-centered ideology internationally known as the midwifery model of care
- Midwives, or practitioners of the midwifery model of care, as the primary practitioners for normal birth
- Midwifery care based in the community
- Continuity of care (caseload midwifery, one-to-one care)
- Creative use of appropriate technologies and modalities that work to support normal birth
- A focus on avoiding morbidity as well as mortality through providing optimal care
- Cultural appropriateness and sensitivity
- Physicians providing appropriate services for high-risk and emergency births
- Mutually respectful and collaborative relationships among all types of care providers
- “Referring back,” meaning that is a woman with a previous risk condition improves and becomes low-risk, she can be reclassified as “normal” and referred back to the midwife
- Reflective practice, in which practitioners continually reflect on what they are doing and make efforts at improvement on an ongoing basis
- Viable systems of transport to hospitals for out-of-hospital practices
- Mutual accommodation and cooperation between professional and Indigenous practitioners
- Effective and appropriate use of lifesaving interventions like caesarean sections
- Evidence-based practice
- Statistically sound outcomes
- Accessibility to women of all income levels
- Effective systems of communication and referral with other community organizations and services
- Financial viability, including cost-effective mix of skills, technology use, and setting, and sufficient salaries for staff
- Sustainability
- Replicability within similar cultural and economic settings
- Practitioner education that encourages and facilitates all of the above
- Regional and national organizations and communication networks that support this work, which include major communication networks that can generate political support and facilitate practitioners in their abilities to humanize care

From (Davis-Floyd et al., 2009, pp. 22–23)

### Appendix B: Dates of midwifery regulation in Canada

| Province/Territory      | Date of Midwifery Regulation |
|-------------------------|------------------------------|
| Alberta                 | 1998                         |
| British Columbia        | 1998                         |
| Manitoba                | 2000                         |
| New Brunswick           | 2016                         |
| Newfoundland & Labrador | 2016                         |
| Northwest Territories   | 2005                         |
| Nova Scotia             | 2009                         |
| Nunavut                 | 2011                         |
| Ontario                 | 1994 (December 31, 1993)     |
| Prince Edward Island    | Not regulated                |
| Quebec                  | 1999                         |
| Saskatchewan            | 2008                         |
| Yukon Territory         | Not Regulated                |

Data from (Canadian Association of Midwives, 2018a)

**Appendix C: Nova Scotia location**

Retrieved from <http://www.kidzone.ws/geography/novascotia/>  
(DLTK's Inc., 2016)

## Appendix D: Ethics Approval Certificates



### Nova Scotia Health Authority Research Ethics Board

Centre for Clinical Research, Room 118  
5790 University Avenue  
Halifax, Nova Scotia, Canada B3H 1V7

October 30, 2017

Ms. Danielle Macdonald

**Delegated Review  
Full Approval Letter  
(October 30, 2017 to October 30, 2018)**

Dear Ms. Macdonald:

RE: Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study

**NSHA REB ROMEO File #: 1022738**

Thank you for your response regarding your proposed study.

| Document Name                   | Comments                                                                               | Version Date |
|---------------------------------|----------------------------------------------------------------------------------------|--------------|
| Supporting Materials            | E-poster & Paper poster V2                                                             | 2017/08/29   |
| Supporting Materials            | Letters of information V2 - midwives nurses mothers stakeholders health care providers | 2017/08/29   |
| Research Protocol               | V2                                                                                     | 2017/08/29   |
| Consent Form                    | Focus Groups V2                                                                        | 2017/08/29   |
| Consent Form                    | Individual Interviews V2                                                               | 2017/08/29   |
| Letter of Support               | From Association of Nova Scotia Midwives                                               | 2017/09/26   |
| Letter of Support               | From Midwifery Coalition of Nova Scotia                                                | 2017/08/28   |
| Letter of Support               | Letter of Support - SMRH (revised)                                                     | 2017/07/07   |
| Investigator Response/Revisions | Cover letter - response to requested revisions                                         | 2017/10/27   |

I have reviewed these documents on behalf of the Research Ethics Board (REB) and note that all requested changes have been incorporated.

I am now pleased to confirm the Board's full approval for this research study, effective today. This includes approval / favorable opinion for the following study documents:

| Document Name                          | Comments                 | Version Date |
|----------------------------------------|--------------------------|--------------|
| Certificate of Completion TCPS 2: CORE | TCPS2 Certification - SI | 2012/03/01   |
| Certificate of Completion TCPS 2: CORE | TCPS2 Certificate - PI   | 2016/01/18   |

|                                       |                                                                                        |            |
|---------------------------------------|----------------------------------------------------------------------------------------|------------|
| Consent Form                          | Focus Groups V2                                                                        | 2017/08/29 |
| Consent Form                          | Individual Interviews V2                                                               | 2017/08/29 |
| Curriculum Vitae (CV)                 | Abbreviated CV – SI Josephine Etowa                                                    | 2017/07/25 |
| Curriculum Vitae (CV)                 | Abbreviated CV – SI Megan Aston                                                        | 2017/05/23 |
| Curriculum Vitae (CV)                 | Abbreviated CV - PI                                                                    | 2017/07/26 |
| Investigator Response/Revisions       | Cover letter - response to requested revisions                                         | 2017/10/27 |
| Letter of Support                     | Association of Nova Scotia Midwives                                                    | 2017/09/26 |
| Letter of Support                     | Midwifery Coalition of Nova Scotia                                                     | 2017/08/28 |
| Letter of Support                     | SMRH (revised)                                                                         | 2017/07/07 |
| Letter of Support                     | IWK Health Centre: Birth Unit                                                          | 2017/07/21 |
| Letter of Support                     | IWK Health Centre: FNASU & Midwifery Services                                          | 2017/05/31 |
| Letter of Support                     | Collaborating Department - South Shore Regional Hospital                               | 2017/07/18 |
| Letter of Support                     | SI Department                                                                          | 2017/05/23 |
| Letter of Support                     | PI Department                                                                          | 2017/05/30 |
| Other                                 | NSHA Letter of Appointment - SI                                                        | 2017/04/18 |
| Other                                 | Correspondence from another REB -UOttawa                                               | 2016/02/14 |
| Research Protocol                     | V2                                                                                     | 2017/08/29 |
| Researcher's Checklist for Submission | Researcher's Checklist                                                                 | 2017/07/27 |
| Researcher's Commitment Form          | Researcher's Commitments: SI Megan Aston                                               | 2017/05/23 |
| Researcher's Commitment Form          | Researcher's Commitments: SI Josephine Etowa                                           | 2017/07/25 |
| Supporting Materials                  | E-poster & Paper poster V2                                                             | 2017/08/29 |
| Supporting Materials                  | Letters of information V2 - midwives nurses mothers stakeholders health care providers | 2017/08/29 |
| Supporting Materials                  | Interview Guides -V1                                                                   | 2017/07/27 |
| Supporting Materials                  | Document Review Data Extraction Form - V1                                              | 2017/07/27 |
| Supporting Materials                  | Contact Information Form - V1                                                          | 2017/07/27 |
| Supporting Materials                  | Focus Group Discussion Guide - V1                                                      | 2017/07/27 |
| Supporting Materials                  | Pre-interview Demographic Profile - V1                                                 | 2017/07/27 |

## Continuing Review

1. The Board's approval for this study will expire one year from the date of this letter **October 30, 2018**. To ensure continuing approval, submit a Request for Annual Approval to the Board 2-4 weeks prior to this date. If approval is not renewed prior to the anniversary date, the Board will close your file and you must cease all study activities immediately. To reactivate a study, you must submit a new Initial Submission (together with the usual fee) to the REB and await notice of re-approval.

2. Please be sure to notify the Board of any:

\* Proposed changes to the initial submission (i.e., new or amended study documents or supporting materials),

\* Additional information to be provided to study participants,

\* Material designed for advertisement or publication with a view to attracting participants,

\* Serious unexpected adverse reactions experienced by local participants,

\* Unanticipated problems involving risks to participants or others,

\* Sponsor-provided safety information,

\* Additional compensation available to participants,

\* Upcoming audits /inspections by a sponsor or regulatory authority,

\* Premature termination / closure of the study (within 90 days of the event).

3. Approved studies may be subject to internal audit. Should your research be selected for audit, the Board will advise you and indicate any other requests at that time.

### **Important Instructions and Reminders**

1. Submit all correspondence to Ethics Coordinator, Pamela Trenholm at the address listed at the top of this letter (do not send your response to the REB Chair or Co-Chair).
2. Login to the Research Portal; click Applications (Post Review), browse through files to locate the study in which you wish to make revisions to; click the Events Button and choose the type of revision you wish to make from the table provided; complete the electronic form and attach document under the attachments tab if required and Click on the Submit button.
3. Be sure to reference the Board's assigned file number, Romeo No. 1022738, on all communications.
4. Highlight all changes on revised documents, and remember to update version numbers and/or dates.

Best wishes for a successful study.

Yours very truly,

Anne Marie Krueger-Naug, MD, FRCPC, PhD  
Co-Chair, NSHA Research Ethics Board

This statement is in lieu of Health Canada's Research Ethics Board Attestation:

The Research Ethics Board for the Nova Scotia Health Authority operates in accordance with:

- Food and Drug Regulations, Division 5 "Drugs for Clinical Trials Involving Human Subjects"
- Natural Health Products Regulations, Part 4 "Clinical Trials Involving Human Subjects"
- Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2)
- ICH Good Clinical Practice: Consolidated Guideline (ICH-E6)

**cc: Lisa Underwood, Director, Research Services**

File Number: H12-16-13

Date (mm/dd/yyyy): 12/12/2017



**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

## Certificate of Ethics Approval

### Health Sciences and Science REB

#### Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

| <u>First Name</u> | <u>Last Name</u> | <u>Affiliation</u>        | <u>Role</u>        |
|-------------------|------------------|---------------------------|--------------------|
| Josephine         | Etowa            | Health Sciences / Nursing | Supervisor         |
| Danielle          | MacDonald        | Health Sciences / Nursing | Student Researcher |

File Number: H12-16-13

Type of Project: PhD Thesis

Title: Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study

Approval Date (mm/dd/yyyy)

12/12/2017

Expiry Date (mm/dd/yyyy)

12/11/2018

Special Conditions / Comments:

N/A



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Nova Scotia B3K 6R8  
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tel: 902.470.8888  
www.iwk.nshealth.ca

**Approval – Delegated Review  
November 20, 2017**

**Principal Investigator:** Ms. Danielle Macdonald

**Supervisor:** Dr. Megan Aston/Dr. Josephine Etowa

**Title:** Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study

**Project #:**1022738

On behalf of the IWK Research Ethics Board (IWK-REB) I have reviewed the documents included in this study. I am pleased to confirm the Board's full approval for this research study, effective today.

Best wishes for a successful study.

Yours truly,

Adam Huber  
Co-Chair, Research Ethics Board

This approval includes the following study documents:

| Document Name                                    | Version Date |
|--------------------------------------------------|--------------|
| Appendix H: Pre-Interview Demographic Profile V2 | 2017/11/16   |
| Appendix F - E-poster & Paper poster V3          | 2017/11/16   |
| Contact Information Form V2                      | 2017/11/16   |
| Letters of Information V3                        | 2017/11/16   |
| Focus group consent form V3                      | 2017/11/16   |
| Individual Interview Consent form V3             | 2017/11/16   |
| Protocol V2                                      | 2017/08/29   |
| Document Review Data Extraction Form - V1        | 2017/07/27   |
| Focus Group Discussion Guide - V1                | 2017/07/27   |

The Board's approval for this study will expire one year from the date of this letter (October 30, 2018). To ensure continuing approval, submit a Request for Continuing Review to the Board 2 - 4 weeks prior to the renewal date. If approval is not renewed prior to the anniversary date, the Board will close your file and you must cease all study activities immediately. To reactivate a study, you must submit a new Initial Submission (together with the usual fee, if applicable) to the IWK-REB and await notice of re-approval.

## Appendix E: Letters of Information for Midwives, Nurses, Mothers



# Université d'Ottawa • University of Ottawa

Faculté des sciences de la santé  
École des sciences infirmières

Faculty of Health Sciences  
School of Nursing

**Study Title:** Exploring collaboration between midwives and nurses in Nova Scotia:  
A feminist poststructuralist case study

Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study is research study that aims to explore how midwives and nurses are collaborating in Nova Scotia, Canada. This exploration of collaboration between midwives and nurses will be used to support midwifery, perinatal nursing, and birthing care in Nova Scotia, and Canada. This research will address a gap in knowledge about collaboration between midwives and nurses. The findings of this research will contribute to strengthening and improving policies and practices to ensure the equitable distribution of midwifery services in Nova Scotia, and in Canada.

**Are you;**

- **A Registered Midwife currently practicing in Nova Scotia?**
- **A Registered Midwife who has practiced in Nova Scotia within the last 2 years?**
- **A Registered Midwives who is currently registered with the Midwifery Council of Nova Scotia?**
- **Fluent in English?**

If so, we invite you to take part in our study to share your **beliefs, values, and practices** regarding collaboration between midwives and nurses in Nova Scotia.

Joining this study will involve taking part in a 1-1.5 hour individual interview. You will be asked to complete a short demographic profile prior to the completion of the individual interview. You will also be invited to participate in a follow-up focus group discussion of study findings.

**Your participation in this study is entirely voluntary and private. Participation will be first come first served.**

**For more information** about joining this study, please contact:

Danielle Macdonald RN PhD(c) Student Researcher  
(Supervisor: Josephine Etowa RN PhD)

Romeo No. 1022738

Version 3: November 16, 2017



## Université d'Ottawa • University of Ottawa

Faculté des sciences de la santé  
École des sciences infirmières

Faculty of Health Sciences  
School of Nursing

**Study Title:** Exploring collaboration between midwives and nurses in Nova Scotia:  
A feminist poststructuralist case study

Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study is research study that aims to explore how midwives and nurses are collaborating in Nova Scotia, Canada. This exploration of collaboration between midwives and nurses will be used to support midwifery, perinatal nursing, and birthing care in Nova Scotia, and Canada. This research will address a gap in knowledge about collaboration between midwives and nurses. The findings of this research will contribute to strengthening and improving policies and practices to ensure the equitable distribution of midwifery services in Nova Scotia, and in Canada.

**Are you;**

- **A Registered Nurse who is currently practicing at one of the three sites where midwifery services are offered in Nova Scotia?**
- **A Registered Nurse who has practiced at one of the three sites where midwifery services are offered in Nova Scotia within the last 2 years?**
- **A Registered Nurse who is working in perinatal care (labour and delivery, postpartum, or at home births as a home birth attendant) at one of the three sites where midwifery services are offered in Nova Scotia?**
- **A Registered Nurse who is currently registered with the College of Registered Nurses of Nova Scotia?**
- **Fluent in English?**

If so, we invite you to take part in our study to share your **beliefs, values, and practices** regarding collaboration between midwives and nurses in Nova Scotia.

Joining this study will involve taking part in a 1-1.5 hour individual interview. You will be asked to complete a short demographic profile prior to the completion of the individual interview. You will also be invited to participate in a follow-up focus group discussion of study findings.

**Your participation in this study is entirely voluntary and private. Participation will be first come first served.**

**For more information** about joining this study, please contact:

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**Are you;**

- **A mother who has received midwifery care within the jurisdiction of one of the sites offering midwifery services in Nova Scotia within the last 2 years?**
- **A mother who has received care from both a Registered Nurse and a Registered Midwife during labour/delivery/24 hours postpartum at home or in the hospital in Nova Scotia?**
- **18 years of age or over?**
- **Fluent in English?**

If so, we invite you to take part in our study to share your **beliefs, values, and practices** regarding collaboration between midwives and nurses in Nova Scotia.

Joining this study will involve taking part in a 1-1.5 hour individual interview. You will be asked to complete a short demographic profile prior to the completion of the individual interview. You will also be invited to participate in a follow-up focus group discussion of study findings.

**Your participation in this study is entirely voluntary and private. Participation will be first come first served.**

**For more information** about joining this study, please contact:

Danielle Macdonald RN PhD(c) Student Researcher  
(Supervisor: Josephine Etowa RN PhD)

## Appendix F: Poster



## Are you interested in strengthening collaboration between midwives and nurses in Nova Scotia?

### Share your experiences and insights

#### Who

- **Registered Midwives** who have practiced in Nova Scotia in the last 2 years
- **Registered Nurses** who have provided perinatal care where midwifery services are offered in the last 2 years
- **Health care providers** who have provided perinatal care where midwifery services are offered in the last 2 years
- **Mothers** who have received perinatal care from collaborating midwives & nurses in the last 2 years
- **Administrative stakeholders** who have provided leadership regarding midwifery integration in Nova Scotia since 2009

**\*Participants must be 18 years of age or over**

**What:** Individual interviews

**When:** TBA

**Time:** 60-90 minutes

**Location:** TBA

For more information, please contact  
Danielle Macdonald

## Appendix G: Letters of Information for Stakeholders, Health Care Providers



# Université d'Ottawa • University of Ottawa

Faculté des sciences de la santé  
École des sciences infirmières

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School of Nursing

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Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study is research study that aims to explore how midwives and nurses are collaborating in Nova Scotia, Canada. This exploration of collaboration between midwives and nurses will be used to support midwifery, perinatal nursing, and birthing care in Nova Scotia, and Canada. This research will address a gap in knowledge about collaboration between midwives and nurses. The findings of this research will contribute to strengthening and improving policies and practices to ensure the equitable distribution of midwifery services in Nova Scotia, and in Canada.

- **Are you a leader with a vested interest in the collaboration between midwives and nurses in Nova Scotia?**
- **Have you held a leadership role at any time since midwifery was regulated in Nova Scotia (2009)?**
- **Are you fluent in English?**

If so, we invite you to take part in our study to share your **beliefs, values, and practices** regarding collaboration between midwives and nurses in Nova Scotia.

Joining this study will involve taking part in a 1-1.5 hour individual interview. You will be asked to complete a short demographic profile prior to the completion of the individual interview. You will also be invited to participate in a follow-up focus group discussion of study findings.

**Your participation in this study is entirely voluntary and private. Participation will be first come first served.**

**For more information** about joining this study, please contact:

Danielle Macdonald RN PhD(c) Student Researcher  
(Supervisor: Josephine Etowa RN PhD)



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Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study is research study that aims to explore how midwives and nurses are collaborating in Nova Scotia, Canada. This exploration of collaboration between midwives and nurses will be used to support midwifery, perinatal nursing, and birthing care in Nova Scotia, and Canada. This research will address a gap in knowledge about collaboration between midwives and nurses. The findings of this research will contribute to strengthening and improving policies and practices to ensure the equitable distribution of midwifery services in Nova Scotia, and in Canada.

- **Are you currently practicing at one of the three sites where midwifery services are offered in Nova Scotia?**
- **Have you practiced within the last 2 years at one of the three sites where midwifery services are offered in Nova Scotia?**
- **Are you currently registered with regulatory body of their profession?**
- **Are you fluent in English?**

If so, we invite you to take part in our study to share your **beliefs, values, and practices** regarding collaboration between midwives and nurses in Nova Scotia.

Joining this study will involve taking part in a 1-1.5 hour individual interview. You will be asked to complete a short demographic profile prior to the completion of the individual interview. You will also be invited to participate in a follow-up focus group discussion of study findings.

**Your participation in this study is entirely voluntary and private. Participation will be first come first served.**

**For more information** about joining this study, please contact:

Danielle Macdonald RN PhD(c) Student Researcher  
(Supervisor: Josephine Etowa RN PhD)

## Appendix H: Contact form for focus group



By providing my email address OR phone number below, I am expressing my interest in being contacted by Danielle Macdonald for follow-up focus group discussion regarding the study *Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study*.

| <u>Name</u> | <u>E-mail Address</u> | <u>Phone</u> |
|-------------|-----------------------|--------------|
|             |                       |              |

## Appendix I: Interview Consent Form

NSHA Research Ethics Board  
Non-Interventional Study Consent Form



### Informed Consent Form Non-Interventional Study – Individual Interviews

**STUDY TITLE:**

**Exploring collaboration between  
midwives and nurses in Nova Scotia:  
A feminist poststructuralist case study**

**PRINCIPAL INVESTIGATOR:**

Danielle Macdonald RN PhD(c)

Faculty of Health Sciences,  
School of Nursing, University of Ottawa

**SUPERVISING INVESTIGATOR:**

Josephine Etowa RN PhD, Full Professor  
Faculty of Health Sciences,

School of Nursing, University of Ottawa

**SUPERVISING INVESTIGATOR:**

Megan Aston RN PhD, Full Professor  
Faculty of Health

School of Nursing, Dalhousie University



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## 1. Introduction

You have been invited to take part in a PhD research study, *Collaboration between midwives and nurses: A feminist poststructuralist case study* which is being conducted by Danielle Macdonald, University of Ottawa, whose research is under the supervision of Dr. Josephine Etowa.

You have been asked to participate because of your collaborative experiences and expertise as a midwife, nurse, or mother and/or your understanding of collaboration between midwives and nurses in Nova Scotia.

You may participate in the study if you are:

- a midwife or nurse working in one of the three areas in Nova Scotia that offers midwifery services
- a mother who has received care from a midwife and a nurse within the last two years,
- a perinatal health care provider who has worked with collaborating midwives and nurses,
- or if you have had a leadership or administrative role related to midwifery and nursing collaboration in Nova Scotia

Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

You may take as much time as you wish to decide whether or not to participate. Feel free to discuss it with your friends and family.

Please ask the research team to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

The researchers will:

- Discuss the study with you
- Answer your questions
- Be available during the study to deal with problems and answer questions

If you decide not to take part or if you leave the study early, your current or future employment status and/or work performance evaluations and/or usual health care will not be affected.



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## **2. Why Is This Study Being Conducted?**

Midwifery was regulated as a health care profession in Nova Scotia in 2009. Despite the continuous proximity of midwives and nurses to each other during hospital and home births, little is known about collaboration between midwives and nurses. The purpose of this research is to explore collaboration between midwives and nurses in Nova Scotia. Using a qualitative approach, this research will contribute to filling a knowledge gap about how midwives and nurses collaborate. This study will provide new information about how midwives and nurses are collaborating in Nova Scotia. A better understanding of the collaborative experiences of midwives and nurses has the potential to strengthen policies and practices for collaborative birthing care in Nova Scotia, and in Canada.

## **3. How Long Will I Be In The Study?**

It is anticipated that the time commitment for participants will be 60-90 minutes for one individual interview, at a location convenient for you. Telephone or skype interviews can be arranged if a face to face interview is not possible.

You will be asked if you are willing to be contacted for a voluntarily focus group lasting 60 minutes at a future date. Total time commitment for you will be 60-90 minutes, with the potential of an additional 60 minutes if you also voluntarily choose to participate in a focus group.

It is expected that interviews and focus group will occur over a period of six months. The entire study is expected to take about 1 year to complete and the results should be known in 18 months.

## **4. How Many People Will Take Part In This Study?**

It is anticipated that about 23-25 people will participate in this study throughout Nova Scotia. About eight people will participate in this study affiliated with each of the participating institutions; St. Martha's Regional Hospital, South Shore Regional Hospital, and the IWK Health Centre.

Participants will include; Registered Midwives, Registered Nurses, Mothers, Health Care Provider Colleagues (doulas, physicians), and Administrative Stakeholders (managers, policy makers) who have provided/received perinatal care at each of the three participating institutions listed previously.



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## 5. How Is The Study Being Done And What Will Happen If I Take Part In This Study?

If you agree to participate in this study you will be asked to:

1. Complete a short demographic profile (5-10 minutes).
2. Participate in a 60-90 minute face-to-face interview with the Primary Investigator (Danielle Macdonald). The interview will occur at place and a time that is convenient for you. All questions will be asked in English. The interview will be audio-recorded with your consent.
3. Respond to questions related to your experiences, perspectives, and understandings about collaboration between midwives and nurses in Nova Scotia. You will be asked about how your experiences, perspectives, and understandings about collaboration between midwives and nurses have been shaped and influenced.
4. You may also be asked if you wish to be contacted to take part voluntarily in a focus group discussion at a future time. Study findings will be shared and participants will have an opportunity to provide feedback. If you wish to take part in the focus group discussion, you may fill out a separate contact information form at the end of the interview. The Primary Investigator will contact you at a future date to make arrangements for your voluntary participation in a focus group.

If you do not want to be audio-recorded during the interview, the Primary investigator, will request permission to take notes during the interview.

Your participation in this study is voluntary and you may choose to have a break from the interview, to decline answering specific questions, to or to withdraw from the study at any time.

If you decide to withdraw from the study, you will contact principal investigator by either telephone or email. Once you have withdrawn from the study, you are free not to follow any or all of the procedures described above. After data analysis we may only be able to remove data from your demographic profile, but not all the ideas you have shared in the interview if these ideas have been integrated into the analyzed and interpreted findings of the study. Data collected in interviews can be removed if you withdraw from the study prior to analysis completion. Once analysis has begun, data cannot be removed due to the complexity of the data analysis.



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## 6. Are There Risks To The Study?

The potential risks for your voluntary participation in this research are minimal but may include unforeseen psychological or emotional discomfort related to the disclosure of personal information during an interview. If you become emotionally or psychologically upset when discussing your experiences during the interviewing process you will have several options;

- to have a break from the interview
- to decline answering specific questions
- to withdraw from the study completely

You will be provided with a list of appropriate resources where you may seek help if discussing your experiences is too upsetting and you would like further assistance.

An additional risk of your participation in this research is the potential for a breach of confidentiality. As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk, including;

- Protecting your identity with a pseudonym and/or code number. Each interview will be assigned a pseudonym and each demographic profile will receive a study code. The list matching names and pseudonyms/codes will be kept separately in a secure location and will not be disclosed to anyone. Only the principal investigator, and her thesis supervisor, Dr. Josephine Etowa, will have access to pseudonyms/codes that can be linked to your identity. The audiotape of your interview will be identified only by this pseudonym and your real name will not be connected to them in any way. Although no one can absolutely guarantee confidentiality, using a pseudonym and/or code number makes the chance much smaller that someone other than the principal investigator and thesis supervisor will ever be able to link your name.

## 7. Are There Benefits Of Participating In This Study?

We cannot guarantee or promise that you will receive any benefits from this research.

Although you may not have any direct benefit from taking part in this study; the ideas, experiences, and challenges that you share may contribute to strengthening future policies and practices concerning midwifery, perinatal nursing, and birthing services in Nova Scotia, and in Canada.

Your participation may or may not help the delivery of midwifery and maternal-newborn health care in Nova Scotia in the future.



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## 8. What Happens at the End of the Study?

It is anticipated that the results of this study will be published and or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.

## 9. What Are My Responsibilities?

As a study participant you will be expected to:

- Follow the directions of the research team.
- Respond to questions related to your experiences, perspectives, and understandings about collaboration between midwives and nurses in Nova Scotia.
- Report any problems that you experience that you think might be related to participating in the study;

## 10. Can My Participation in this Study End Early?

Yes. If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the research team. If you choose to withdraw from this study, your decision will have no effect on your current employment or future medical treatment and healthcare.

You may decline to answer any questions, withdraw comments, or withdraw from the study up until analysis is completed. After data analysis we may only be able to remove data from your demographic profile, but not all the ideas you have shared in the interview, if these ideas have been integrated into the analyzed and interpreted findings of the study. Data collected in interviews can be removed if you withdraw from the study prior to analysis completion. Once analysis has begun, data cannot be removed due to the complexity of the data analysis. If you choose to withdraw from the study after data analysis or publication of the findings, your data will be destroyed to prevent its use in other research projects.

A decision to stop being in the study will not affect your employment status or work performance evaluations you may have.



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Also, the University of Ottawa Research Ethics Board, the Nova Scotia Health Authority Research Ethics Board, the IWK Health Centre Research Board, and the principal investigator have the right to stop recruitment or cancel the study at any time.

Lastly, the principal investigator may decide to remove you from this study without your consent for any of the following reasons:

- You do not follow the directions of the research team;
- You are experiencing side effects that are harmful to your health or well-being;
- There is new information that shows that being in this study is not in your best interests;
- 

If you are withdrawn from this study, the Primary Investigator will discuss the reasons with you.

## 11. What About New Information?

You will be told about any other new information that might affect your health, welfare, or willingness to stay in the study and will be asked whether you wish to continue taking part in the study or not.

## 12. Will It Cost Me Anything?

Participating in this study may or may not result in added costs to you such as costs for parking or transportation depending on your choice of location for the individual interview. Out of pocket expenses will not be reimbursed for this study.

## 13. What About My Privacy and Confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. If the results of this study are presented to the public, nobody will be able to tell that you were in the study. Your name will not appear in any report or publication of the research. Each interview will be assigned a pseudonym and each demographic profile will receive a study code. The list matching the names to the pseudonyms and code numbers will be kept separately in a secure location and will not be disclosed to anyone. Only the Primary Investigator and the Thesis Supervisor will have access to the pseudonyms and codes that can be linked to participant identities. In future reports or presentations coming from this research, all information that could be used to identify you, your employer, colleagues, clients/patients, place of work and so on will be substituted with fictional or generic names. Identifying demographic features will not be described, or will be disguised to provide confidentiality.

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REB Version3: 2017/11/16



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However, complete privacy cannot be guaranteed. Depending on the location you choose for the interview, anonymity and confidentiality of may not be guaranteed. For example, the Principal Investigator will keep what you share in the interview confidential, except in situations where she is required by law to release the research records (e.g., if we hear information that a child has been or is being abused; if we hear that you may harm yourself, that is, there is reason to believe that you are at risk to commit suicide; or if we hear that someone has threatened your life or someone else's life, etc.).

### Access to Records

Other people may need to look at your personal information to check that the information collected for the study is correct and to make sure the study followed the required laws and guidelines. These people might include:

- The Nova Scotia Health Authority Research Ethics Board (NSHA REB) and people working for or with the NSHA REB because they oversee the ethical conduct of research studies within the Nova Scotia Health Authority.
- The IWK Health Centre Research Ethics Board (IWK REB) and people working for or with the IWK REB because they oversee the ethical conduct of research studies within the IWK Health Centre.
- The University of Ottawa Research Ethics Board (University of Ottawa REB) and people working for or with the University of Ottawa REB because they oversee the ethical conduct of research studies within the University of Ottawa.

### Use of Your Study Information

Any study data about you that is sent outside of the Nova Scotia Health Authority will have a pseudonym and/or code number and will not contain your name or address, or any information that directly identifies you.

De-identified study data may be transferred to:

- Thesis Committee, University of Ottawa
- Transcriptionist hired to transcribe audio-recorded interviews

Study data that is sent outside of the Nova Scotia Health Authority will be used for the research purposes explained in this consent form.

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Although the thesis committee members (other than the principal investigator) or transcriptionist will not know your name, they will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Information sent to the thesis committee members or transcriptionist will be password protected. Transcriptionists will sign a confidentiality agreement and he/she will destroy all electronic files upon completion of her work on this project.

In any reports coming from this research all information that could be used to identify you (e.g., employer, colleagues, place of work and so on) will be substituted with fictional or generic names/pseudonyms. Identifying demographic features will not be described, or will be disguised to provide confidentiality. The results of this study may be described in oral and written presentations and may be published in professional journals. However, at all times only aggregated results will be reported and no personal identifiers will be used.

The demographic profiles and interview transcripts will be kept in a locked filing cabinet in a secured office of the doctoral student's supervisor, Dr. Josephine Etowa RN, at the University of Ottawa, School of Nursing. We will store the consent form and your contact information separate from research data. The audio-recorded interview will be downloaded onto a password-protected computer and be transcribed into written texts as a password protected document. Once the transcription is completed, we will store the audio files on password-protected computers. These computers will be stored in a locked filing cabinet in a secured office. Only the research team will have access to this office. All raw data; audio-recordings, demographic profiles, interview transcripts, and notes will be destroyed 7 years after the study has been completed.

The research team and the other people listed above will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

After your part in the study ends, we may continue to review your information for data accuracy until the study is finished or you withdraw your consent.

You have the right to be informed of the results of this study once the entire study is complete.

The REB and people working for or with the REB may also contact you personally for quality assurance purposes.

Romeo File No. 1022738

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## 14. Declaration of Financial Interest

This study is unfunded. The Primary Investigator has no vested financial interest in conducting this study.

## 15. What About Questions or Problems?

For further information about the study you may call the principal investigator, who is the person in charge of this study and/or any other research team member listed below.

**Principal Investigator:** Danielle Macdonald RN PhD(c)

**Supervising Investigator:** Josephine Etowa RN PhD, Full Professor,

**Supervising Investigator:** Megan Aston RN PhD, Full Professor

## 16. What Are My Rights?

- You have the right to all information that could help you make a decision about participating in this study.
- You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction before you make any decision.
- You also have the right to ask questions and to receive answers throughout this study.
- You have the right to access, review, and request changes to your study data.



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- You have the right to be informed of the results of this study once the entire study is complete.

If you have any questions about your rights as a research participant, contact Patient Relations at (902) 473-2133 or [healthcareexperience@nshealth.ca](mailto:healthcareexperience@nshealth.ca)

If you are calling us long distance (NS, NB and PEI), please use our toll free number 1-855-799-0990.

If you have any questions regarding your rights as a research participant or the conduct of this research you can contact the University of Ottawa Protocol Officer at the Office of Research Ethics and Integrity, Tabaret Hall, 550 Cumberland St. Room 154, Ottawa, ON, K1N 6N5 at (613) 562-5367  
[ethics@uottawa.ca](mailto:ethics@uottawa.ca)

In the next part you will be asked if you agree (consent) to join this study. If the answer is “yes”, please sign the form.



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## 17. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

**Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study**

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my employment status and/or work performance evaluations and/or future care.

- ☐ I **agree** to audio recordings as described in this consent form.

☐ I **do not agree** to audio recordings as described in this consent form.

|                                                                            |                         |                                             |
|----------------------------------------------------------------------------|-------------------------|---------------------------------------------|
| _____<br>Signature of Participant                                          | _____<br>Name (Printed) | ____ / ____ / ____<br>Year    Month    Day* |
|                                                                            |                         |                                             |
| _____<br>Signature of Person Conducting<br>(Printed)<br>Consent Discussion | _____<br>Name           | ____ / ____ / ____<br>Year    Month    Day* |
|                                                                            |                         |                                             |
| _____<br>Signature of Investigator                                         | _____<br>Name (Printed) | ____ / ____ / ____<br>Year    Month    Day* |

*\*Note: Please fill in the dates personally*

**I will be given a signed copy of this consent form.**

## Appendix J: Demographic Profile



Participants will be asked to complete the following demographic information at the beginning of the individual interviews.

Please specify the title of your current position: \_\_\_\_\_

Please provide a brief description of your current role: \_\_\_\_\_

How long have you worked in Nova Scotia? \_\_\_\_\_years \_\_\_\_\_months

How long have you worked in your current position? \_\_\_\_\_years \_\_\_\_\_months

How long have you been practicing in your profession/field ? \_\_\_\_\_years \_\_\_\_\_months

What is your educational background? (please check all that apply)

- ☐ High School
- ☐ Diploma, specify: \_\_\_\_\_
- ☐ Bachelor Degree, specify: \_\_\_\_\_
- ☐ Graduate Degree, specify: \_\_\_\_\_

Is there anything else you would like to share about yourself?

### For mothers:

How long have you lived in Nova Scotia? \_\_\_\_\_

Who provided care to you during your

- ☐ pregnancy \_\_\_\_\_
- ☐ labour \_\_\_\_\_
- ☐ delivery \_\_\_\_\_
- ☐ postpartum \_\_\_\_\_

When did you access maternity care? \_\_\_\_\_

## **Appendix K: Semi-structured Interview Guides for Midwives, Nurses, Mothers, Stakeholders, Health Care Providers**

### **Semi-Structured Interview Guide – Midwives**

This interview guide is meant to guide the researcher during the conduct of the participant interviews. As a guide, it is not necessary to attend to all the questions systematically or in full. The responses of the participant will also guide the interview.

Thank you for agreeing to participate in this interview. Your experiences and perspectives of collaboration between midwives and nurses are important for helping to develop a better understanding of how these two professions work with one another. I am particularly interested in hearing about your experiences and understandings of collaboration between midwives and nurses.

- 1) What does collaboration mean to you? (Tell me more)
- 2) Tell me about your experiences of collaboration in a maternity care setting? (How does that make you feel? Are you saying...?)
- 3) Tell me about midwifery in Nova Scotia? (How does that make you feel? Are you saying?)
- 4) Tell me about perinatal nursing in Nova Scotia? (How does that make you feel? Are you saying?)
- 5) Tell me about midwives and nurses working together in Nova Scotia? (How does that make you feel? Tell me more)
- 6) Tell me about your experiences working with nurses? (How does that make you feel? Tell me more)
- 7) Please provide an example of working with a nurse... (What did you do? What did the nurse do? Please describe that to me in more detail?)
  - a) How did those experiences make you feel? (Tell me more)
  - b) How did those experiences reflect your beliefs about collaboration?
- 8) What are the strengths of your experience(s) working with nurses? (How does that make you feel? Tell me more)
- 9) How could collaboration between midwives and nurses be strengthened in Nova Scotia? (Are you saying? Tell me more.. It sounds like..)
- 10) How has collaboration between midwives and nurses in Nova Scotia been shaped and influenced? (How does that make you feel? Tell me more)
- 11) What would you change about how midwives and nurses collaborate in Nova Scotia? (Are you saying? Tell me more)
- 12) Is there anything else that you would like to share?

**Prompts:** Tell me more... How does/did that make you feel? It sounds like... Are you saying..?

### Semi-Structured Interview Guide – Nurses

This interview guide is meant to guide the researcher during the conduct of the participant interviews. As a guide, it is not necessary to attend to all the questions systematically or in full. The responses of the participant will also guide the interview.

Thank you for agreeing to participate in this interview. Your experiences and perspectives of collaboration between midwives and nurses are important for helping to develop a better understanding of how these two professions work with one another. I am particularly interested in hearing about your experiences and understandings of collaboration between midwives and nurses.

- 1) What does collaboration mean to you? (Tell me more)
- 2) Tell me about your experiences of collaboration in a maternity care setting? (How does that make you feel? Are you saying...?)
- 3) Tell me about midwifery in Nova Scotia? (How does that make you feel? Are you saying?)
- 4) Tell me about perinatal nursing in Nova Scotia? (How does that make you feel? Are you saying?)
- 5) Tell me about midwives and nurses working together in Nova Scotia? (How does that make you feel? Tell me more)
- 6) Tell me about your experiences working with midwives? (How does that make you feel? Tell me more)
- 7) Please provide an example of working with a midwife... (What did you do? What did the nurse do? Please describe that to me in more detail?)
  - a. How did those experiences make you feel? (Tell me more)
  - b. How did those experiences reflect your beliefs about collaboration?
- 8) What are the strengths of your experience(s) working with midwives? (How does that make you feel? Tell me more)
- 9) How could collaboration between midwives and nurses be strengthened in Nova Scotia? (Are you saying? Tell me more.. It sounds like..)
- 10) How has collaboration between midwives and nurses in Nova Scotia been shaped and influenced? (How does that make you feel? Tell me more)
- 11) What would you change about how midwives and nurses collaborate in Nova Scotia? (Are you saying? Tell me more)
- 12) Is there anything else that you would like to share?

**Prompts:** Tell me more... How does/did that make you feel? It sounds like... Are you saying..?

### Semi-Structured Interview Guide – Mothers

This interview guide is meant to guide the researcher during the conduct of the participant interviews. As a guide, it is not necessary to attend to all the questions systematically or in full. The responses of the participant will also guide the interview.

Thank you for agreeing to participate in this interview. Your experiences and perspectives of collaboration between midwives and nurses are important for helping to develop a better understanding of how these two professions work with one another. I am particularly interested in hearing about your experiences and understandings of collaboration between midwives and nurses.

- 1) What does collaboration mean to you? (Tell me more)
- 2) Tell me about your experiences of collaboration in a maternity care setting? (How does that make you feel? Are you saying...?)
- 3) Tell me about midwifery in Nova Scotia? (How does that make you feel? Are you saying?)
- 4) Tell me about perinatal nursing in Nova Scotia? (How does that make you feel? Are you saying?)
- 5) Tell me about midwives and nurses working together in Nova Scotia? (How does that make you feel? Tell me more)
- 6) Tell me about your experiences of midwives and nurses collaborating.. Please provide an example of your experience of a midwife and a nurse working together.. (what did the nurse and midwife do? what did you do? please describe that to me in more detail?)
  - a) How did those experiences make you feel? (Tell me more)
  - b) How did those experiences reflect your beliefs about collaboration?
- 7) What are the strengths of your experience(s) of midwives and nurses collaborating? (How does that make you feel? Tell me more)
- 8) How could collaboration between midwives and nurses be strengthened in Nova Scotia? (Are you saying? Tell me more.. It sounds like..)
- 9) How has collaboration between midwives and nurses in Nova Scotia been shaped and influenced? (How does that make you feel? Tell me more)
- 10) What would you change about how midwives and nurses collaborate in Nova Scotia? (Are you saying? Tell me more)
- 11) Is there anything else that you would like to share?

**Prompts:** Tell me more... How does/did that make you feel? It sounds like... Are you saying..?

### Semi-Structured Interview Guide – Administrative Stakeholders

This interview guide is meant to guide the researcher during the conduct of the participant interviews. As a guide, it is not necessary to attend to all the questions systematically or in full. The responses of the participant will also guide the interview.

Thank you for agreeing to participate in this interview. Your experiences and perspectives of collaboration between midwives and nurses are important for helping to develop a better understanding of how these two professions work with one another. I am particularly interested in hearing about your experiences and understandings of collaboration between midwives and nurses.

- 1) What does collaboration mean to you? (Tell me more)
- 2) Tell me about your experiences of collaboration in a maternity care setting? (How does that make you feel? Are you saying...?)
- 3) Tell me about midwifery in Nova Scotia? (How does that make you feel? Are you saying?)
- 4) Tell me about perinatal nursing in Nova Scotia? (How does that make you feel? Are you saying?)
- 5) Tell me about midwives and nurses working together in Nova Scotia? (How does that make you feel? Tell me more)
- 6) Tell me about your experiences of midwives and nurses collaborating.. Please provide an example of your experience of a midwife and a nurse working together.. (what did the nurse and midwife do? what did you do? please describe that to me in more detail?)
  - c) How did those experiences make you feel? (Tell me more)
  - d) How did those experiences reflect your beliefs about collaboration?
- 7) What are the strengths of your experience(s) of midwives and nurses collaborating? (How does that make you feel? Tell me more)
- 8) How could collaboration between midwives and nurses be strengthened in Nova Scotia? (Are you saying? Tell me more.. It sounds like..)
- 9) How has collaboration between midwives and nurses in Nova Scotia been shaped and influenced? (How does that make you feel? Tell me more)
- 10) What would you change about how midwives and nurses collaborate in Nova Scotia? (Are you saying? Tell me more)
- 11) Is there anything else that you would like to share?

**Prompts:** Tell me more... How does/did that make you feel? It sounds like... Are you saying..?

### **Semi-Structured Interview Guide – Health Care Provider Colleagues**

This interview guide is meant to guide the researcher during the conduct of the participant interviews. As a guide, it is not necessary to attend to all the questions systematically or in full. The responses of the participant will also guide the interview.

Thank you for agreeing to participate in this interview. Your experiences and perspectives of collaboration between midwives and nurses are important for helping to develop a better understanding of how these two professions work with one another. I am particularly interested in hearing about your experiences and understandings of collaboration between midwives and nurses.

- 1) What does collaboration mean to you? (Tell me more)
- 2) Tell me about your experiences of collaboration in a maternity care setting? (How does that make you feel? Are you saying...?)
- 3) Tell me about midwifery in Nova Scotia? (How does that make you feel? Are you saying?)
- 4) Tell me about perinatal nursing in Nova Scotia? (How does that make you feel? Are you saying?)
- 5) Tell me about midwives and nurses working together in Nova Scotia? (How does that make you feel? Tell me more)
- 6) Tell me about your experiences of midwives and nurses collaborating.. Please provide an example of your experience of a midwife and a nurse working together.. (what did the nurse and midwife do? what did you do? please describe that to me in more detail?)
  - a. How did those experiences make you feel? (Tell me more)
  - b. How did those experiences reflect your beliefs about collaboration?
- 7) What are the strengths of your experience(s) of midwives and nurses collaborating? (How does that make you feel? Tell me more)
- 8) How could collaboration between midwives and nurses be strengthened in Nova Scotia? (Are you saying? Tell me more.. It sounds like..)
- 9) How has collaboration between midwives and nurses in Nova Scotia been shaped and influenced? (How does that make you feel? Tell me more)
- 10) What would you change about how midwives and nurses collaborate in Nova Scotia? (Are you saying? Tell me more)
- 11) Is there anything else that you would like to share?

**Prompts:** Tell me more... How does/did that make you feel? It sounds like... Are you saying..?

**Appendix L: Document Review Form**  
 Informed by (Stake, 1995)

**Title of document:** \_\_\_\_\_

**Author of document:** \_\_\_\_\_

**Type of document:** \_\_\_\_\_ **Intended audience of document:** \_\_\_\_\_

**Date document was created:** \_\_\_\_\_ **Date document was received:** \_\_\_\_\_

| <b>Relevant points related to collaboration between midwives and nurses</b> |
|-----------------------------------------------------------------------------|
|                                                                             |

| <b>What is absent about collaboration between midwives and nurses</b> |
|-----------------------------------------------------------------------|
|                                                                       |

| <b>Identified Discourses</b> |
|------------------------------|
|                              |

## Appendix M: Semi-structured Discussion Group Guides for Midwives and Nurses

### Preamble:

I am conducting focus group discussions as a follow up with the participants in this research study *Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study*. The data collection included \_\_\_\_ (#) individual interviews and a review of \_\_\_\_ (#) documents. The purpose of this focus group is to review the findings and analysis with you, and to facilitate a focused discussion with you about the findings and any further insights and recommendations that you might have. This discussion should take no more than 60 minutes, and we would like everyone to have the chance to give their opinion.

Before beginning our conversation, we would like you to review the information sheet and consent form provided, ask any questions you might have about the focus group, and sign the form if you feel comfortable in participating today.

**Presentation of Key Findings & Preliminary Analysis:** 15-20 minute power point - TBD

### Discussion Questions:

1. What are your reactions to the findings from this research? [Probes: What resonates for you? What surprises you? How do they make you feel?]
2. When you hear what has emerged in terms of collaboration between midwives and nurses in Nova Scotia, is this similar to or different from what you had imagined? How is it similar or different from what you imagined? [Probes: Does it make sense to you? Is there anything missing?]
3. With respect to recommendations, do they cover the main areas you would want highlighted? [Probes: What additional recommendations would you want included? Are there any that you are questioning/wondering about their relevance?]
4. What additional questions has this research raised for you? [Probe: If there was an opportunity to do more research about collaboration between midwives and nurses, what do you think would be important to focus on? What are some research priorities in the area of collaboration between midwives and nurses? In perinatal care regarding midwifery and perinatal nurses?]

## Appendix N: Discussion Group Consent Form



### Informed Consent Form Non-Interventional Study – Focus Groups

**STUDY TITLE:**

**Exploring collaboration between  
midwives and nurses in Nova Scotia:  
A feminist poststructuralist case study**

**PRINCIPAL INVESTIGATOR:**

Danielle Macdonald RN PhD(c)  
Faculty of Health Sciences,  
School of Nursing, University of Ottawa

**SUPERVISING INVESTIGATOR:**

Josephine Etowa RN PhD, Full Professor  
Faculty of Health Sciences,  
School of Nursing, University of Ottawa

**SUPERVISING INVESTIGATOR:**

Megan Aston RN PhD, Full Professor  
Faculty of Health  
School of Nursing, Dalhousie University

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## 1. Introduction

You have been invited to take part in a PhD research study, *Collaboration between midwives and nurses: A feminist poststructuralist case study* which is being conducted by Danielle Macdonald, University of Ottawa, whose research is under the supervision of Dr. Josephine Etowa.

You have been asked to participate because of your collaborative experiences and expertise as a midwife, nurse, or mother and/or your understanding of collaboration between midwives and nurses in Nova Scotia.

You may participate in the study if you are:

- a midwife or nurse working in one of the three areas in Nova Scotia that offers midwifery services
- a mother who has received care from a midwife and a nurse within the last two years,
- a perinatal health care provider who has worked with collaborating midwives and nurses,
- or if you have had a leadership or administrative role related to midwifery and nursing collaboration in Nova Scotia

Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

You may take as much time as you wish to decide whether or not to participate. Feel free to discuss it with your friends and family.

Please ask the research team to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

The researchers will:

- Discuss the study with you
- Answer your questions
- Be available during the study to deal with problems and answer questions

If you decide not to take part or if you leave the study early, your current or future employment status and/or work performance evaluations and/or usual health care will not be affected.



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## **2. Why Is This Study Being Conducted?**

Midwifery was regulated as a health care profession in Nova Scotia in 2009. Despite the continuous proximity of midwives and nurses to each other during hospital and home births, little is known about collaboration between midwives and nurses. The purpose of this research is to explore collaboration between midwives and nurses in Nova Scotia. Using a qualitative approach, this research will contribute to filling a knowledge gap about how midwives and nurses collaborate. This study will provide new information about how midwives and nurses are collaborating in Nova Scotia. A better understanding of the collaborative experiences of midwives and nurses has the potential to strengthen policies and practices for collaborative birthing care in Nova Scotia, and in Canada.

## **3. How Long Will I Be In The Study?**

Total time commitment for you will be 60 minutes if you voluntarily choose to participate in a focus group.

It is expected that interviews and focus group will occur over a period of six months. The entire study is expected to take about 1 year to complete and the results should be known in 18 months.

## **4. How Many People Will Take Part In This Study?**

It is anticipated that about 23-25 people will participate in this study throughout Nova Scotia. About eight people will participate in this study affiliated with each of the participating institutions; St. Martha's Regional Hospital, South Shore Regional Hospital, and the IWK Health Centre.

Participants will include; Registered Midwives, Registered Nurses, Mothers, Health Care Provider Colleagues (doulas, physicians), and Administrative Stakeholders (managers, policy makers) who have provided/received perinatal care at each of the three participating institutions listed previously.



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## 5. How Is The Study Being Done And What Will Happen If I Take Part In This Study?

If you agree to participate you will be asked to:

1. Participate in a 60 minute face-to-face focus group discussion with other midwives or nurses. There will be a separate focus group for nurses and a separate focus group for midwives. The group discussion will occur at a place and a time that is convenient for you. All questions will be asked in English. The focus group discussion will be audio-recorded.
2. Study findings from the individual interviews will be presented to you and you will have an opportunity to provide feedback about the study findings. Since the meeting involves numerous participants, your agreement to be audio-taped is a criteria to take part in this consultation meeting. Anonymity and confidentiality cannot be guaranteed.
3. Respond to questions regarding the findings of the research study. You will be asked how the findings reflect your experiences, perspectives, and understandings about collaboration between midwives and nurses in Nova Scotia.

Your participation in this study is voluntary and you may choose to have a break from the interview, to decline answering specific questions, to or to withdraw from the study at any time.

If you decide to withdraw from the study, you will contact principal investigator by either telephone or email. Once you have withdrawn from the study, you are free not to follow any or all of the procedures described above. It is important to note that data cannot be removed after participation in focus group discussions, due to the nature of group conversation.

## 6. Are There Risks To The Study?

The potential risks for your voluntary participation in this research are minimal but may include unforeseen psychological or emotional discomfort related to the disclosure of personal information during an interview. If you become emotionally or psychologically upset when discussing your experiences during the interviewing process you will have several options;

- to have a break from the interview
- to decline answering specific questions
- to withdraw from the study completely



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You will be provided with a list of appropriate resources where you may seek help if discussing your experiences is too upsetting and you would like further assistance.

An additional risk of your participation in this research is the potential for a breach of confidentiality. As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk.

Whilst all care will be taken throughout the focus group discussion, you may experience embarrassment if one of the group members were to repeat things said in a confidential group meeting. The concealment of your identity cannot be guaranteed because participation in a group precludes concealment of your identity and enhances risks for a breach of confidentiality to the information shared in-group. In addition, while all participants may agree to keep matters discussed by the group in confidence, there is always a risk that the agreement may not be honoured.

## **7. Are There Benefits Of Participating In This Study?**

We cannot guarantee or promise that you will receive any benefits from this research.

Although you may not have any direct benefit from taking part in this study; the ideas, experiences, and challenges that you share may contribute to strengthening future policies and practices concerning midwifery, perinatal nursing, and birthing services in Nova Scotia, and in Canada.

Your participation may or may not help the delivery of midwifery and maternal-newborn health care in Nova Scotia in the future.

## **8. What Happens at the End of the Study?**

It is anticipated that the results of this study will be published and or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.



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## 9. What Are My Responsibilities?

As a study participant you will be expected to:

- Follow the directions of the research team;
- Respond to questions related to your experiences, perspectives, and understandings about collaboration between midwives and nurses in Nova Scotia.
- Report any problems that you experience that you think might be related to participating in the study;

## 10. Can My Participation in this Study End Early?

Yes. If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the research team. If you choose to withdraw from this study, your decision will have no effect on your current employment or future medical treatment and healthcare.

You may decline to answer any questions, withdraw comments, or withdraw from the study up until analysis is completed. After data analysis we may only be able to remove data from your demographic profile, but not all the ideas you have shared in the interview, if these ideas have been integrated into the analyzed and interpreted findings of the study. Data collected in interviews can be removed if you withdraw from the study prior to analysis completion. Once analysis has begun, data cannot be removed due to the complexity of the data analysis. If you choose to withdraw from the study after data analysis or publication of the findings, your data will be destroyed to prevent its use in other research projects.

It is important to note that data cannot be removed after participation in focus group discussions, due to the nature of group conversation.

After data analysis we may only be able to remove data from your demographic profile.

A decision to stop being in the study will not affect your employment status or work performance evaluations you may have.

Also, the University of Ottawa Research Ethics Board, the Nova Scotia Health Authority Research Ethics Board, the IWK Health Centre Research Board, and the principal investigator have the right to stop recruitment or cancel the study at any time.



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Lastly, the principal investigator may decide to remove you from this study without your consent for any of the following reasons:

- You do not follow the directions of the research team;
- You are experiencing side effects that are harmful to your health or well-being;
- There is new information that shows that being in this study is not in your best interests;

If you are withdrawn from this study, the Primary Investigator will discuss the reasons with you.

## **11. What About New Information?**

You will be told about any other new information that might affect your health, welfare, or willingness to stay in the study and will be asked whether you wish to continue taking part in the study or not.

## **12. Will It Cost Me Anything?**

Participating in this study may or may not result in added costs to you such as costs for parking or transportation. Out of pocket expenses will not be reimbursed for this study.

## **13. What About My Privacy and Confidentiality?**

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. If the results of this study are presented to the public, nobody will be able to tell that you were in the study. Your name will not appear in any report or publication of the research. Each interview will be assigned a pseudonym and each demographic profile will receive a study code. The list matching the names to the pseudonyms and code numbers will be kept separately in a secure location and will not be disclosed to anyone. Only the Primary Investigator will have access to the pseudonyms and codes that can be linked to participant identities. In future reports or presentations coming from this research, all information that could be used to identify you, your employer, colleagues, clients/patients, place of work and so on will be substituted with fictional or generic names. Identifying demographic features will not be described, or will be disguised to provide confidentiality.

However, complete privacy cannot be guaranteed. Your anonymity cannot be guaranteed due to the presence of other participants in the focus group. Participants will be invited to keep the information that



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is shared during the focus group, however, confidentiality of the information shared in the group cannot be guaranteed. The Primary Investigator will keep what you share in the interview confidential, except in situations where she is required by law to release the information (e.g., if we hear information that a child has been or is being abused; if we hear that you may harm yourself, that is, there is reason to believe that you are at risk to commit suicide; or if we hear that someone has threatened your life or someone else's life, etc.). All participants of the focus group discussion will be reminded that the conversation within the focus group is to remain confidential.

### Access to Records

Other people may need to look at your personal information to check that the information collected for the study is correct and to make sure the study followed the required laws and guidelines. These people might include:

- The Nova Scotia Health Authority Research Ethics Board (NSHA REB) and people working for or with the NSHA REB because they oversee the ethical conduct of research studies within the Nova Scotia Health Authority.
- The IWK Health Centre Research Ethics Board (IWK REB) and people working for or with the IWK REB because they oversee the ethical conduct of research studies within the IWK Health Centre.
- The University of Ottawa Research Ethics Board (University of Ottawa REB) and people working for or with the University of Ottawa REB because they oversee the ethical conduct of research studies within the University of Ottawa.

### Use of Your Study Information

Any study data about you that is sent outside of the Nova Scotia Health Authority will have a pseudonym and/or code number and will not contain your name or address, or any information that directly identifies you.

De-identified study data may be transferred to:

- Thesis Committee, University of Ottawa
- Transcriptionist hired to transcribe audio-recorded interviews

Study data that is sent outside of the Nova Scotia Health Authority will be used for the research purposes explained in this consent form.

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Although the thesis committee members (other than the principal investigator) or transcriptionist will not know your name, they will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Information sent to the thesis committee members or transcriptionist will be password protected. Transcriptionists will sign a confidentiality agreement and he/she will destroy all electronic files upon completion of her work on this project.

In any reports coming from this research all information that could be used to identify you (e.g., employer, colleagues, place of work and so on) will be substituted with fictional or generic names/pseudonyms. Identifying demographic features will not be described, or will be disguised to provide confidentiality. The results of this study may be described in oral and written presentations and may be published in professional journals. However, at all times only aggregated results will be reported and no personal identifiers will be used.

The demographic profiles and interview/focus group transcripts will be kept in a locked filing cabinet in a secured office of the doctoral student's supervisor, Dr. Josephine Etowa RN, at the University of Ottawa, School of Nursing. We will store the consent form and your contact information separate from research data. The audio-recorded interview will be downloaded onto a password-protected computer and be transcribed into written texts as a password protected document. Once the transcription is completed, we will store the audio files on password-protected computers. These computers will be stored in a locked filing cabinet in a secured office. Only the research team will have access to this office. All raw data; audio-recordings, demographic profiles, interview transcripts, and notes will be destroyed 7 years after the study has been completed.

The research team and the other people listed above will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

After your part in the study ends, we may continue to review your information for data accuracy until the study is finished or you withdraw your consent.

You have the right to be informed of the results of this study once the entire study is complete.

The REB and people working for or with the REB may also contact you personally for quality assurance purposes.

Romeo File No. 1022738

REB Version 3: 2017/11/16



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## 14. Declaration of Financial Interest

This study is unfunded. The PI has no vested financial interest in conducting this study.

## 15. What About Questions or Problems?

For further information about the study you may call the principal investigator, who is the person in charge of this study and/or any other research team member listed below.

**Principal Investigator:** Danielle Macdonald RN PhD(c)

**Supervising Investigator:** Josephine Etowa RN PhD, Full Professor,

**Supervising Investigator:** Megan Aston RN PhD, Full Professor

## 16. What Are My Rights?

- You have the right to all information that could help you make a decision about participating in this study.
- You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction before you make any decision.
- You also have the right to ask questions and to receive answers throughout this study.
- You have the right to access, review, and request changes to your study data.
- You have the right to be informed of the results of this study once the entire study is complete.



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If you have any questions about your rights as a research participant, contact Patient Relations at (902) 473-2133 or [healthcareexperience@nshealth.ca](mailto:healthcareexperience@nshealth.ca)

If you are calling us long distance (NS, NB and PEI), please use our toll free number 1-855-799-0990.

If you have any questions regarding your rights as a research participant or the conduct of this research you can contact the University of Ottawa Protocol Officer at the Office of Research Ethics and Integrity, Tabaret Hall, 550 Cumberland St. Room 154, Ottawa, ON, K1N 6N5 at (613) 562-5367 [ethics@uottawa.ca](mailto:ethics@uottawa.ca)

In the next part you will be asked if you agree (consent) to join this study. If the answer is “yes”, please sign the form.



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## 17. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the study called:

**Exploring collaboration between midwives and nurses in Nova Scotia: A feminist poststructuralist case study**

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

I authorize access to my personal information, and research study data as explained in this form.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my employment status and/or work performance evaluations and/or future care.

☐ I **agree** to audio recordings as described in this consent form.

☐ I **agree** to keep everything discussed in this group strictly confidential.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Name (Printed)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Year Month Day\*

\_\_\_\_\_  
Signature of Person Conducting  
(Printed)  
Consent Discussion

\_\_\_\_\_  
Name

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Year Month Day\*

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Name (Printed)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Year Month Day\*

*\*Note: Please fill in the dates personally*

**I will be given a signed copy of this consent form.**