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Social Theory & Health, 2008, 6, (132–147)
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Domination or Mutual Recognition? Professional Subjectivity in Midwifery and Obstetrics

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Traditional rivalries between midwives and obstetricians continue to generate tension, mistrust and poor communication in many maternity care settings. The resulting negative emotional climate affects workplace well-being and the care of birthing women. To address these problems, this paper uses critical social theory to consider the ways in which midwifery and obstetrics continue to be positioned, and position themselves, as the 'Other' against which each can be defined. The first section reports on fieldwork observations and interview data from qualitative research into professional work in maternity units in Victoria, Australia. In order to interpret the ways in which professional conflicts are experienced, the paper then develops a conceptual framework drawn from historical sociology of the professions, psychoanalytic debates on subjectivity, and moral and feminist philosophy concerning disrespect and domination. As the search for recognition by the 'Other' profession has become distorted into domination, it is argued, aspects of each professional identity became split off and projected onto the Other. The paper argues that remedying inter-professional conflicts therefore requires replacing long-standing, and deeply gendered, dualism with the dialectical process of mutual recognition.
Social Theory & Health (2008) **6,** 132–147. doi:10.1057/palgrave.sth.2007.12

Keywords: midwifery; obstetrics; professional culture; identity; recognition; conflict

INTRODUCTION

In recent years, the introduction of new models of maternity services in Australia has been reshaping working patterns and relationships within midwifery, which comprises the major workforce, and also with doctors. Expectations of multidisciplinary collaboration, increasingly built into policy,

presuppose effective communication, mutual respect and more egalitarian professional relationships rather than traditional hierarchical authority. While organizational innovations such as team-based and caseload midwifery have been implemented with varying degrees of success in some hospitals, underlying professional cultures often remain problematic. Reports have described Australian midwifery as demoralized (Cullen and Martins, 1996; Brodie, 2002), and British midwifery culture has been reported as reflecting a feminine ideal of 'service and sacrifice' in which midwives feel unsupported (Kirkham, 1999). In midwifery professional discussions, the idea that midwives behave as an oppressed group is commonly expressed, and midwifery professionalization has led to new forms of conflict with doctors that affect attempts to restructure services. Anecdotal, press and research evidence indicates that recurrent disputes over professional boundaries are a notable feature of the present Australian maternity care system (Hirst, 2005). While there is no systematic information available concerning the impact of such conflict on birthing women, stories that circulate in consumer circles make reference to which staff were 'on my side' in managing labour. In the light of such tensions, this paper establishes an interdisciplinary theoretical approach to consider the complexity of relationships between doctors and midwives. It also has implications for thinking about care provision.

Although professional 'turf wars' are not unknown in other fields, the depth and passion of those in maternity care are remarkable, no doubt reflecting the intense emotional and social significance of birth itself. As anthropologists such as Davis-Floyd (1994) point out, childbirth is situated at the boundary between biological and cultural processes and its management is always indicative of core cultural values. Marking out territory takes on not only practical but also symbolic importance. There have been many accounts of medical and midwifery power struggles (Donnison, 1977; Willis, 1983; Murphy-Lawless, 1998), but they rarely grapple with the emotional or subjective dimensions of conflict. Yet recent research into several Australian maternity care workplaces reveals how professional struggles are lived out at the personal level. Angst and conflict plague many staff but they also report satisfaction when effective collaboration occurs across the professional boundaries (Reiger, 2004; Lane, 2005). While a full report of the empirical evidence is not the primary purpose of this paper, the first section discusses some of this evidence before it then develops a possible interpretive framework. This considers first how the historical development of the professions meant that they became defined in terms of each other, as 'Other' in the very process of identity construction. Critical social theory, especially philosophy and feminist psychoanalysis, are then used in the following

sections to make sense of the self–other dynamics involved in inter-professional interactions between midwives and obstetricians.

WORKING TOGETHER IN MATERNITY CARE

Although it cannot be reported in detail here, in research carried out in public maternity care units Victoria from 2002 to 2005, midwives, unit managers and medical staff shared their stories of both conflict and tensions in the workplace, and of positive experiences in which they felt that mutual trust and respect provided the basis of working together effectively. Most significantly, they provided rich evidence of how intense professional struggles are lived out at the personal level. Interviews with unit managers, senior doctors and one or more midwives from each of five suburban units provided the basis for further investigation in a small rural unit and in a tertiary hospital.[1] At the rural unit, the introduction of a new team midwifery model was explored through repeat interviews and occasional observational work in the unit over a 12-month period in 2003–2004. Four midwives, the unit and senior managers and four local general practitioners were interviewed, along with several other midwives not in the team. In the tertiary hospital, research included fieldwork in staff meetings, shift hand-overs and several antenatal clinics and postnatal wards extending over almost 2 years from 2003 to 2005, accompanied by interviewing and focus groups that included approximately 120 participants. Not only a diversity of midwives, but also a range of junior to senior medical staff were interviewed. This process, along with the fieldwork, produced a very complex data set that was coded and themes were explored using a grounded theory approach supported by NVivo software (QSR 2003). An overwhelming theme emerging in this work, one further supported by research in two other units (Lane, 2006), was that lack of mutual recognition and respect colour professional interactions between Australian midwives and obstetricians. The widespread desire to work well together went hand in hand with considerable incomprehension of the other profession's culture, expectations and difficulties. The lack of mutual understanding was compounded by intense emotions around childbirth and by the strength of many midwives' commitment to normal rather than medicalized childbirth.

While there are differences within as well as between professional groups and sites also vary, recurrent patterns of conflict were reported that involved identity and self-regard, meanings (language usage: patient/woman, labour ward/birth room) and practices (timing of vaginal exams, usage of technology). The frequency of overt conflict is minimized in 'high risk' care

by acceptance of medical authority but can be intense in 'low risk' sites such as family birthing centres in mainstream hospitals in which professional boundaries and processes are 'fuzzy'. The desire to work together was commonly expressed in terms of respect for each other's expertise:

> Medical staff respecting that the midwives know what they're doing and the midwives being able to feel confident with the doctors minding their own but coming in when they're asked. Like a respect. An equal relationship (Midwife tertiary unit).

Midwives wanted doctors to acknowledge and respect them, not just as individuals but professionally. Doctors wanted their specialist training, experience and professional judgement recognized and to be treated as individuals rather than as authoritarian meddlers in normal processes. Yet both groups also reported tensions, distance and antagonistic relationships. A midwife pointed to the power dynamics involved, saying that like many midwives, she was:

> very much anti-obstetrician, because they were bad, we were good. The women were somewhere in between. … there was the tug of war between the power at the top, not the power of the woman (Midwife tertiary unit).

Antagonism was manifested through both overt and covert means. Midwives in particular reported that they felt a lack of professional and personal respect by doctors including physical violation, such as verbal abuse and intimidation, but also denial of their professional rights, such as that to question decisions. Patterns of informal and formal social exclusion were also involved – medical handovers for example, in one large unit did not formally exclude midwives but were held at 8 am, a time when the midwifery workload was too heavy for them to attend. They were also held in a room away from shared work areas and in which midwives did not feel welcome. In a small rural hospital, some disrespect to midwives was shown by doctors repeatedly not coming to joint meetings even though they were scheduled with their practice demands in mind. The doctors complained that they had not been consulted about organizational matters, yet documentation indicated that they had. In not communicating effectively with either midwifery or other medical staff, and in assuming that antenatal clinics had to fit their, rather than midwives', schedules, the doctors associated with this hospital also indicated an absence of consideration for the processes of midwifery work.

Lack of recognition of midwives as a profession was also apparent in the very limited knowledge held by most doctors interviewed, including some quite senior ones, concerning developments such as the politics of midwifery's separation from nursing. Even those who have learnt not to refer to midwives as nurses had little awareness of midwifery professional

issues unless they had worked in units where discussion with midwives about professional awareness was encouraged. Hence some midwives' insistence on demedicalizing language (eg 'birth' not 'delivery', 'women' not 'patients') completely mystified them, that is if they bothered to consider it all. The concept of a midwifery scope of practice was not mentioned by doctors, who mostly just seemed to assume that their medical definitions and judgements should stand. While some doctors were deeply concerned about conflicts and sought to encourage midwives to articulate and stand by their professional opinions, others, especially the more junior ones, interpreted being challenged as disrespectful of medical authority. One such doctor believed it was important to 'respect the midwife [as] the one looking after the woman in labour. It's hard work, it's difficult work and they have a lot of first hand experience' but went on to say that 'but we are trained in a different aspect.' In recounting an incident in which midwives discouraged a junior doctor from going into a birth room, this doctor responded to my question about how he interpreted the midwives' perspective only in terms of his own understanding of control:

> I think this particular midwife ahh [pause] – the way I see it is this. She does not actually have respect enough for the junior medical staff. Thinking she's, she's able to control the situation and she wants to take charge of the situation… That's what my feeling is (Registrar tertiary unit).

Indeed, doctors too felt that they were often treated as the 'Other' in ways that reinforce division, and wanted to still be included in overall care arrangements even with greater midwifery autonomy of practice. Some expressed not merely professional concern but personal pain that midwives treated all of them as equally interventionist: a senior consultant in the tertiary unit often felt like saying 'Give me a break, you don't even know me!' to antagonistic midwives. For some doctors the episodic nature of medical care and their consequent reliance on the close relationship generated by ongoing midwifery care produced anxiety and the frustration of being 'left out'. One staff consultant said somewhat plaintively that obstetricians could also build up a close relationship with mothers if they could afford to spend as much time with them as midwives did. This remark, like many others, was tinged with pain that goes beyond rational argument about respective expertise. Similarly, strong emotion surrounds the not uncommon struggles over space – in one rural hospital a senior obstetrician was reportedly banging on a bathroom door and screaming out to get the Director because the midwife 'would not let him in'. More considered reports come from a doctor wanting to be part of a team effort in a city hospital:

> And you know, there have been situations where we've been forced to kind of wait outside the door, or hide in the corner and pretend we're not there. Even

> though they've asked us to come because, I don't know, big baby, might be shoulder dystocia or whatever, but they don't treat us as one of the team when we get there (RMO tertiary unit).

Midwives of course reply to such complaints with the argument that when doctors become involved they tend to take over:

> [W]hat you tend to hear [is] that a lot of umm, midwives and maybe the younger midwives I'm not sure, they just say, look, as soon as an obstetrician comes into the room, or a doctor, they do stuff. They can't leave alone. They can't, the woman's actually worse off if there's a doctor in the room (Midwife tertiary unit).

Another midwife commented that she did not want to feel, as she commonly did, dismissed or marginalized. Like many others, she reported stories of encounters in which her professional opinion was not respected and she felt personally maligned.

Underlying the overt contests over decision-making in the management of labour and birth, however, are further tensions concerning the emotional connection between the birthing women and her caregivers. In many midwifery discussions the 'high' or 'buzz', the 'magic' of a good birth is reported, and doctors recognize that, as one obstetrician commented, they quite liked being 'wanted, needed, loved to death.' Another said thoughtfully:

> I think many obstetricians want to be loved, as all human beings do, and ah, they become addicted to or hooked on the very powerful relationship that exists for some months if not years in terms of relationship between a private obstetrician and a patient, and it's a two way thing. … it can be a buzz for some people to have people so dependent upon you. [So conflict is about] ownership of the patient … human beings want to be loved, midwives want to be loved by their patients, doctors want to be loved by their patients, and it's umm, you're fighting over your lover (Senior consultant tertiary).

A senior midwife also reflected on the dependency relationship that emerges in the highly charged intimate atmosphere of birth as caregivers and the mother connect with each other:

> [T]heir psyches become entwined just for that moment in time when they are sharing this travail. And each one's identity fuses for the time being through a woman's need and a midwife's role to support, and each one holds the other up until the moment of moment, and then the midwife disengages to allow the family to, you know the woman's real relationships to go back to that. And so I think every midwife, it's like when you get a new puppy, the dependence is there. You see it in a woman's eyes (Midwifery unit manager).

This data has indicated, therefore, not only the complexity of emotional dynamics, but a pattern of mutual distrust and disrespect in the case study sites which, according to senior clinicians and managers, is apparently widespread in the sector. It is clear that professional power relations, notably medical dominance over midwifery, but also midwifery resistance and subversion, have been institutionalized over a long period of time. Most importantly, the data indicates the pain that results as they are lived out through individual perceptions and expectations. The following discussion then seeks to explicate these issues.

THE POLITICS OF PROFESSIONAL 'OTHERING' IN MATERNITY CARE

The obstetric dominance over both childbirth and midwifery that was attained by the 20th century in western societies reflected both internal struggles within medicine and larger historical processes associated with the rise of modernity. The increasing social and political power of the medical profession was based on unifying disparate groups of practitioners and carving out a market for their services (Freidson, 1970). Since at least the 18th century, modern obstetrics has positioned itself as the scientific, prestigious and legitimate alternative to the ancient practice of midwifery. In carving out its own position as a specialty, it also had to establish legitimacy *vis-à-vis* the longer-established fields of general surgery and physiology (Pringle, 1998). In the uneasy process of bridging between gynaecology and obstetrics, obstetrics eventually marginalized general practitioners in many countries, and used particular representations of midwifery to assert greater authority over childbirth. In Australia, but elsewhere too, midwives were largely portrayed as mostly ignorant and even dangerous 'old women' (Reiger, 1985; Murphy-Lawless, 1998). While the competence of some individual practitioners was recognized and effective working relationships established with them, especially in some rural areas, by the early 20th century the medical profession in general denigrated midwifery and urged formalized training within nursing, thus rendering it subject to greater medical control. Although the professional narrative and identity of obstetrics stresses its benign role in saving women and babies from the horrors of high mortality and morbidity rates (Longmore, 2005), critical analysis suggests a more complex process. As McKeown (1976) and others have demonstrated, improved sanitation, nutrition and living conditions were responsible for many benefits commonly but falsely attributed to medical achievements. Furthermore, in childbirth management, several dubious medical practices such as routine episiotomy became commonplace and many were remedied by natural birth advocates in

the 1960s–1970s (Rothman, 1982; Reiger, 2001). Since increased attention has been paid to evidence-based medicine, they have also been critically assessed according to research evidence.

The social construction of knowledge was thus central to the historical processes shaping medicine and midwifery's relationships. They were also deeply gendered of course. Medical, abstract knowledge was demarcated as 'masculine', replacing the traditional, embodied, experiential knowledge associated with women (Broom, 1989). It was not merely that, apart from some 'man-midwives', men were the doctors and women the midwives, but that modern science itself elaborated in new ways cultural dichotomies such as those between reason/emotion, culture/nature, safety/danger, mind/body and purity/uncleanness. As philosophers of science and the environment, Carolyn Merchant and Val Plumwood (Merchant, 1980; Plumwood, 1993) have demonstrated, these dichotomies have a long history of being constructed along gendered lines, with the masculine associated with the more highly valorized term. They argue that privileging the type of knowledge based on modern scientific forms of understanding as the only form of 'truth' was thus a gendered enterprise, one linked to the hierarchical separation of public and private spheres of life characteristic in modern industrial capitalist economies. Through incorporating midwifery into nursing under medical supervision, Australian doctors, like others, expected that midwives would come to recognize the superiority of medicine and accept its authority (Reiger, 1985; Keleher, 2000). As obstetrics emerged as a specialist field therefore, midwifery was discursively positioned as that which scientific medicine was not, a practice based on variable craft skill rather than abstract knowledge, as secondary and to be controlled within a hierarchy of hospital-based nursing. At the same time as this 'othering', obstetric practice also relied on the hands-on caring afforded by midwives/nurses – work devalued though as merely the natural role of women (Broom, 1989). By the later 20th century, as the specialist expertise of obstetrics in dealing with abnormalities was buttressed by increased use of technology, and the concept of the 'active management of labour' became institutionalized, medical hegemony over childbirth became entrenched.

It is hardly surprising then that the subsequent 'rebirth' of midwifery in the late 20th century has been in turn an oppositional process. In countries in which the incorporation into nursing was well-established, it first meant separating from nursing, but also involved an increasingly assertive attempt to challenge doctors over their perceived mismanagement of physiologically normal birth (Donnison, 1977; Rothman, 1982). In the course of establishing the resurgent professional identity of what some have called the 'new midwifery' (Page, 2000), midwives have generally defined themselves as

specialists in managing normal birth and their practice as distinguished by a 'mother–midwife partnership' and by holistic care (Guilliland and Pairman, 1995; Kirkham, 2000). Midwifery participates therefore in the processes of 'othering' by offering a professional narrative in which it occupies the high moral ground *vis-à-vis* doctors – defending women from the danger posed to their health and well-being by interventionist medicine. While many nurse-midwives remain content not to challenge medical authority and status, younger tertiary-educated midwives, particularly those coming from programmes stressing midwifery autonomy, seek a more egalitarian relationship with doctors. Promotion of 'collaborative' or team work by managers and policy-makers though, as well as by doctors and midwives, tends to underplay the emotionally charged rivalry between the professions. This very brief discussion of the historical processes by which two professional groups seek to be 'knights in shining armour' rescuing birthing women establishes that midwifery and obstetrics share a historical legacy of constituting their colleagues in the other profession as 'Other'. More than historical sociological understanding is needed however to explain the intensity and tenacity of these professional positions.

FORMULATING A CRITICAL INTERPRETIVE FRAMEWORK

A way forward can be found by drawing on the concepts of intersubjectivity and mutual recognition as they have been developed in recent years in psychoanalytic and feminist theory and in moral and political philosophy. The theoretical literature points to three important processes: first, those concerning the construction of subjectivity at the individual, but also at the collective level; second, the way in which domination emerges as distortion of self–other relationships; and third, the importance of mutual recognition as forming the basis of social solidarity.

INTERSUBJECTIVITY

The concept of the individual as a separate autonomous self has now been thoroughly challenged in recent social and psychological theory. Rather subjectivity or the state of being a 'subject' or self is seen as constructed through dynamic processes of interaction with others (Chodorow, 1989). Poststructuralist theories in particular encourage us to recognize that subjectivity is multiple and fluid, always contested and unfinished and constituted in and through discourses riddled with power and desire (Flax, 1993; Mansfield, 2001). Informed not only by poststructuralism but by

Frankfurt School critical theory, social psychology, object-relations psychoanalytic theory and self-in-relation theories, Jessica Benjamin argues strongly and persuasively for an understanding of the self in terms of its relations to others. The 'intersubjective view', she says, stresses that our identity, both as individuals and as social groups, is established through social and psychological processes of defining or differentiating ourselves in relation to others. Indeed it is only in forming a connection to an outside 'object', an 'Other', that we can become conscious of ourselves as subjects at all. Yet this process always involves a paradox: 'Recognition is that response from the other which makes meaningful the feelings, intentions and actions of the self… But such recognition can only come from an other whom, in turn, we recognize as a person in his or her own right' (Benjamin, 1988). In later work Benjamin has further stressed that an inevitable tension is involved in the self–other relationship as each strives to juggle their 'sameness' and 'difference' and connect across the space between them. We both reach out to the Other, recognizing their difference, and seek recognition of our identity through being responded to. In this dialectical process, 'two subjectivities, each with its own set of internal relations, begin to create a new set between them' (Benjamin, 1995, p. 3). The bridging of difference however is no simple process of achieving some ideal harmony but a constant struggle in which both negative (self as other to me) and positive (other is like me) dimensions are negotiated to achieve the mutual recognition that is sought (p. 23).

One of Benjamin's most insightful discussions then concerns the breakdown of the 'struggle for recognition' between self and other. She develops Hegel's analysis of the symbiotic relationship between master and slave as only constituted in and through their relationship with each other, using it to explore the dynamics of erotic domination and of historically produced gender oppression. Social as well as personal domination also arises out of distorted self–other relationships she claims. Using psychoanalytic understanding of internal processes of 'splitting' in which undesired or feared aspects of the self are split off and projected onto the Other, Benjamin argues that domination is a 'twisting of the bonds of love' (1988, p. 219). As each needs the acknowledgement of the other, even through negative means, both participate in a dynamic of desire and control. The tension between assertion and even aggression towards another perceived as different from oneself, and simultaneously identifying with them and needing their recognition is, says Benjamin, inevitable. Eschewing any romanticized notion of mutuality she claims that 'negation', the attempt to assert oneself against the other, is essential to subjectivity. However, if the other is not recognized as a separate, independent self which can withstand the assertive or even destructive impulses directed towards them, the subject intensifies the dialectic of control

in order to maintain its own sense of existence (Benjamin, 1988, p. 53). Domination, says Benjamin, begins in a denial of our dependency on others and our attempt to assert ourselves entirely over them and it 'proceeds through the alternate paths of identifying with or submitting to powerful others who personify the fantasy of omnipotence' (p. 219). In particular, Benjamin draws attention to the ways in which such processes have been intrinsic to gender domination. She points to the consequences of the splitting of reason and emotion in modernity and its gendered basis in the valorization of the masculine public world over the sphere of home and family (1988, Chapter 5).

MUTUAL RECOGNITION AS SOCIAL SOLIDARITY

To take Benjamin's framework further, a related discussion of the concept of mutual recognition interprets it not just as the psychological underpinning of egalitarian intersubjective relations, but as the moral basis of social solidarity.

In a significant discussion of 'struggles for recognition', German philosopher Axel Honneth has also developed Hegelian analysis but in combination with arguments of G.H. Mead concerning the internalization of the 'generalized other' as the basis for shared social norms (Honneth, 1996). In terms reminiscent of Habermas's claim that non-distorted or 'ideal' speech provides a normative basis for life, Honneth moves from the level of individual development to those associated with collective life. Like Benjamin, upon whom he also draws, Honneth argues that recognition by another is essential both to individual subjectivity and to establishing social bonds. The development of and barriers to having a sense of a collective 'we' are hence crucial concerns of moral philosophy and political analysis (Honneth, 1996; Fraser and Honneth, 2003). Honneth too argues that only when the collective, like the individual, 'Other' is given moral worth can the process of recognition occur. Honneth formulates the idea of mutual or reciprocal recognition as an 'arc of communication' between self and other, between the ability to 'be alone' as an independent other and be merged or connected to another (p. 105). The value of Honneth's formulation for the analysis of professional tensions lies in his articulation of the forms of disrespect which make the 'arc' impossible to sustain. Moreover, Honneth argues that in understanding the 'moral experience of disrespect' lies a framework for grasping the possibility of relationships being otherwise: that it is through the 'morally motivated struggles of social groups' seeking to expand 'forms of reciprocal recognition' that social change occurs (p. 93). In order to use his analysis for considering the failure of the 'communicative arc' between midwifery and obstetrics, further explication of disrespect is required.

There are, argues Honneth, three forms of social recognition and, accordingly, different forms of disrespect leading to the failure of what he refers to as 'the reciprocity of the intersubjectively suspended arc' (p. 106) or 'the balance between fusion and demarcation' (p. 133). First, with regard to love or emotional concern as found in primary relationships of kin and friends, is a developmental process, one which, following Benjamin, can become distorted towards either excessive dependency or egocentrism. The type of injury most commonly associated with this concerns physical abuse and degradation of the body. Second, at the larger societal level, is the system of legal relations such as those associated with citizenship. In the modern world, rights claims have been based on a universalistic framework, which as a result of social struggle has now broadened to include expectations of social as well as political rights. The form of disrespect that emerges here, suggests Honneth, is that to 'live without individual rights means to have no chance of developing self-respect' (p. 119). In other words, if individuals and groups cannot assert claims to recognition on the basis of publicly acknowledged entitlements (such as to having a voice in decision-making), it is impossible for them to relate positively to themselves with 'self-respect' (p. 120). Denial of rights and social exclusion are the forms of injury flowing from this type of disrespect. Lastly, Honneth argues that a third form of social recognition is associated with the solidarity that emerges from participating in a community of shared values. Mutual esteem is only possible when 'self and other' 'share an orientation to those values and goals that indicate to each other the significance or contribution of their qualities for the life of the other' (p. 121)'. Hence the failure of such mutual esteem means a lack of self-esteem as a distinct form of disrespect. This is accompanied by denigration of ways of life and integrity, thus threatening one's sense of honour and dignity (p. 134). All forms of disrespect, argues Honneth, take on a particular character in view of the individualization of late modern cultures. Rather than forms of disrespect being experienced as applying primarily to one's status group, they are experienced in a more directly personal way as infringements of a sense of personal worth (pp. 128–130). Honneth's reworking of Hegel and Mead is expressly oriented to empirical application, but he notes that this is not easy to undertake as, in many cases, it is only when the 'injustice of disrespect' is present that the underlying system of failed recognition becomes apparent.

To sum up, building on the fundamental concept of mutual recognition as an intrinsically social process –from the intrapsychic level of the individual to the intersubjective processes between individuals, groups and within larger society –Honneth suggests that we can articulate both the goal of mutual recognition as essential to individual well-being and social solidarity, and forms of the 'injustice of disrespect'. There is no space here to discuss the

ongoing debate, especially between Honneth and Fraser, concerning weighting struggles for 'recognition' against those concerning the distribution of material resources (Fraser and Honneth, 2003), but clearly they are closely linked. To conceptualize professional tensions in maternity care as distortions of self–other relationships, one further dimension needs to be addressed – the question of the gendered character of the 'arc' of recognition.

As indicated by my earlier discussion of the gendered character of the emergence of modern science and rationality, women and men have been positioned differently with regard to the possibility of social recognition and the danger of the 'injustice of disrespect'. Val Plumwood in particular has articulated how dualistic thinking is 'often preserved in our conceptual framework as residues, layers of sediment deposited by past oppressions' (Plumwood, 1993). Further developing Simone de Beauvoir's claim that men have been historically established as the 'universal subject', the 'master', and thus have been able to define women as inessential, as 'Other', Plumwood describes several strategies that follow in dualistic systems of power. One is to deny the importance of what women do, seeing it as merely 'background' to the real achievements of the world of culture largely carried out by men. Other strategies include defining the identity of the powerful through polarizing difference and maintaining it as the basis of a hierarchy and defining the 'underside of a dualistically conceived pair…in relation to the upperside as a lack, a negativity' (Plumwood, 1993, p. 52). The claims of medicine, and of obstetrics in particular, to rational scientific 'mastery' thus accord with this logic by implicitly relying on construction of a subordinate other (nursing/midwifery) associated with the lower side of the gendered dualisms of culture/nature and mind/body. The historical processes shaping medical dominance have meant that the search for recognition by the other has become distorted into domination. Midwifery's historically more recent response to medical power in terms of antipathy and largely covert resistance is in danger at least of continuing the cultural logic by 'Othering' obstetrics, but merely reversing the terms.

CONCLUSIONS: OTHERING, DUALISM AND THE SEARCH FOR MUTUAL RECOGNITION

Using both empirical evidence and social theoretical analysis, I have argued that both obstetricians and midwives are caught up in deeply entrenched cultural and psychological dynamics that go beyond overt professional rivalries over status. In a psychoanalytic frame, these cultural dynamics go far beyond the maternity care system and involve complex dependency relationships. The nature of the dependence of each profession on the other, while formally

recognized, remains problematic at a less conscious level. As modern obstetrics cast midwifery as the dangerous 'Other' – closely associated with the danger/pollution/irrationality of birthing women – it can be argued to have split off its own emotionality and anxieties, projecting them onto midwives. When senior doctors engage in rhetorical pronouncements in the media about the danger of any birth without medical supervision, they demean midwives as qualified and knowledgeable birth attendants. They also implicitly deny their own dependence on midwives for the practical management of pain and of bodily processes, for the ways in which midwifery work 'frees' doctors for the abstract and technical work of diagnosis of pathology and treatment. In Plumwood's terms, they see such care work as invisible background to their foreground. The historical and emotional legacy of subordination, however, also positions midwives within this dynamic of splitting and dependency. Like women generally (Miller, 1988), midwives act as 'carriers' of the vulnerability and pain of existence through their work of physical and emotional tending to others. Not only through acceptance of medical dominance by 'obstetric nursing', but even the 'new midwifery' frequently casts midwifery as the stronghold of the social, the caring, and the intuitive as against the domain of science and rational masculine distance. To the extent that, as in some homebirth circles, midwifery stresses its expertise in the management of often ineffable emotional and physical processes, the 'warm and fuzzy', and plays down formal clinical assessment skills, it maintains its side of the dualism. Doctors also become the 'Other' and the value of medical work becomes derided rather than respected in its own domain. Midwifery's struggle for recognition therefore might need to involve not merely a process of assertion with regard to medicine, but also acknowledgement and rejection of its historical collusion in a reciprocal distortion of recognition and associated denial of mutual dependence.

In spite of the recurrent patterns of various forms of disrespect and lack of mutual recognition explored in this paper, we live in unsettled times. The analysis of domination, dualism and dependency offered here cannot capture all the complexity of contemporary Australian maternity care, even at the professional level. Tertiary education of midwives in their distinct discipline, changes in medicine such as the expansion of a social view of health and of evidence-based practice, along with the entry of more women into obstetrics, make for new dynamics. The 1990s have also seen measures associated with neoliberal health reform, which have, paradoxically, opened up new opportunities for contestation (Reiger, 2006). The acute shortage of both midwifery and obstetric staff is prompting increased emphasis on collaborative work and policy recommendations strongly support it (Department of Human Services, 2004). The evidence of the difficulty involved in attempting cultural change in maternity care, even with the best intentions, is also strong

however. It is not merely that appropriate role boundaries between midwifery and medicine are difficult to establish and maintain. Rather, the historical shaping of institutionalized systems of maternity hospitals continues to limit mutual recognition between the professions because they were never established in an egalitarian way. The structure of decision-making, resource allocation and responsibility was and to an extent remains hierarchical. Although, to the chagrin of some old-style doctors, midwifery unit managers now operate successfully at senior levels, and many obstetricians at both consultant and junior levels are women, the historical pattern which gave doctors final authority remains entrenched in many hospital cultures. It shapes authoritative knowledge, policy-making processes in the state and professional discourse (Lane, 2005; Reiger, 2006). Hierarchical patterns of medical dominance are reinforced through psychological patterns, underlie interpersonal interactions and are quite literally built into the maternity system's organization of space and time. Without addressing these intransigent issues, collaborative practice based on mutual recognition will remain unachievable.

Acknowledgements
Fuller details of the research than can be reported here are available from the author. The 'Constructing collaboration: professional identities and cultures in maternity care' research has been funded by a La Trobe University Faculty grant and collaborative grants between La Trobe University and two hospitals. My thanks go to the many midwives in particular, but also doctors and others, who have shared their experiences with me, and to my research assistants, Elisabeth Speller, Bonnie Simons and Annie Dennis.

ENDNOTE

1 See Acknowledgements.

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